Montana Teen Pregnancy Report

May, 2008

Trends in Teen Pregnancies and Their Outcomes in Montana

1991-2005

Montana Department of Public Health and Human Services
Public Health and Safety Division
Family and Community Health Bureau
Women's and Men's Health Section

MONTANA
Department of Public Health & Human Services

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HOW TO USE THIS REPORT

The *Trends in Teen Pregnancies and Their Outcomes in Montana* report is published by the Montana Department of Public Health and Human Services, Women's and Men's Health Section. The report is intended to highlight trends related to statewide teen pregnancy rates, health disparities, protective and risk factors over a fifteen year period, and encourages local communities to build capacity toward teen pregnancy prevention efforts. Please reference the Definition of Terms found at the end of this report.

Pregnancies are estimated by counting live births, fetal deaths (weighing 350 grams or more or greater than 20 weeks gestation, if the weight is unknown) and induced abortions reported to the Montana Office of Vital Statistics. This number is most likely an underestimation of the actual number of pregnancies, as it does not include unreported pregnancies, or miscarriages that occur early in pregnancy. Pregnancies and live births are reported for Montana residents only. Live births, miscarriages, and abortions that occurred to Montana residents outside of Montana may not be included in this number. Not all states record the same statistics or consistently report such vital events to other states. The denominator data for all rates and tables is based on population estimates from The National Center for Health Statistics.[28]

Pregnancy rates are calculated by dividing the number of pregnancies to females ages 15-19 by the estimated midyear population of 15-19 year old females (produced by the Census Bureau), and multiplying the result by 1,000. Rates are reported as the number of pregnancies per 1,000 population of females ages 15-19.

Families and communities are the most influential factors in a teen's life, and can make the most progress in teen pregnancy prevention. Many communities and individuals throughout Montana are currently mobilized to prevent teen pregnancy. In honor of their work, we have included profiles of such efforts throughout this report.

Numerous teen pregnancy prevention stakeholders rely on this report including: state program staff, decision-makers (such as county commissioners, tribal leaders, and legislators), non-governmental organizations (such as Big Brother Big Sisters), youth-service organizations, schools, AmeriCorps*VISTA members, doctors, nurses, public health staff, teachers, administrators, and community members.

Information from this report is most commonly used to:

1. Compare with other risk behavior data
2. Generate public awareness
3. Locate resources on teen pregnancy prevention
4. Influence decision-makers
5. Apply for program funding
6. Create a community-specific needs assessment.

HOW TO USE THIS REPORT

Though an overview of various statewide teen pregnancy indicators from the Montana Prevention Needs Assessment (PNA) and the Youth Risk Behavior Survey (YRBS) are presented in this report, we encourage readers to review the PNA and YRBS for more detailed data on any specific indicator for their community.

In addition to this report, supplemental materials, as well as links to further resources, are published on the Women's and Men's Health Section Website. These materials include data tables for Montana counties, tools for conducting local needs assessments, resources for families and educators, capacity-building tools, and supplemental reports.

For an electronic copy of this report or an alternate format, contact:
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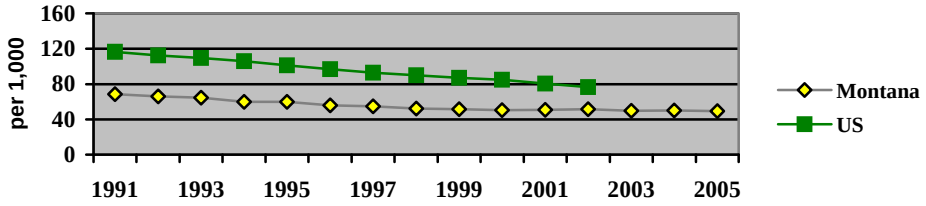
OVERVIEW

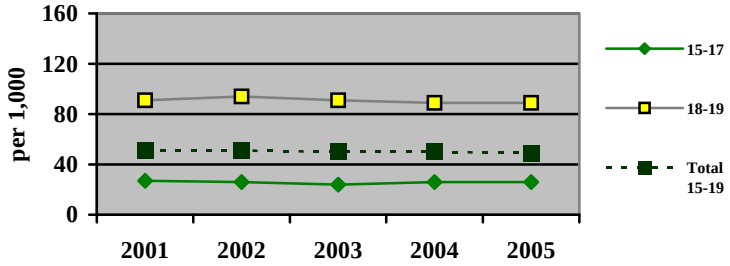
Teen pregnancy rates in Montana and the nation have declined between 1991 and 2005. However, the decline in Montana teen pregnancy rates occurred primarily between 1991 (69 per 1,000) and 1999 (52 per 1,000) when the rate decreased 33%. National teen pregnancy rates after 2002 are not yet available. Preliminary state and national birth data from 2006 indicates an increase in teen pregnancy and birth rates from the previous year.[1]

Figure 1: Teen pregnancy rates, females, ages 15-19, Montana and US, 1991-2005



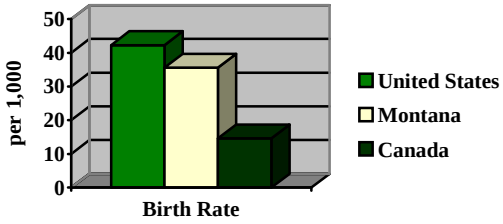
The Montana teen pregnancy rate remained relatively stable between 2000 (51 per 1,000) and 2005 (49 per 1,000), with a 5-year rate (2001-2005) of 50 pregnancies per 1,000. Most teen pregnancies in Montana occurred to teens 18 and 19 years of age.

Figure 2: Teen pregnancy rates, females, by age group, Montana, 2001-2005



Montana teen pregnancy rates are lower than national rates, but the United States still ranks among the highest in the developed world for teen pregnancies.

Figure 3: Average teen birth rates, females, ages 15-19, 2001-2005



The teen pregnancy rate in the United States is estimated to be more than twice as high as that in neighboring Canada.[2,3] However, methods of calculating teen pregnancy rates differ between countries and the same timeframes are not always available. A more standard comparison is teen birth rates, which still indicate that both the US and Montana have much higher rates than Canada.[1,4]

Teen pregnancy rates among American Indians, Montana's largest minority group, are significantly higher than the statewide rate. While one in five Montana females will become pregnant before the age of 20, two in three American Indian females will become pregnant before age 20. In 2005, the teen pregnancy rate for Montana American Indians was 127 per 1,000, compared with 49 per 1,000 for the state as a whole.

OVERVIEW

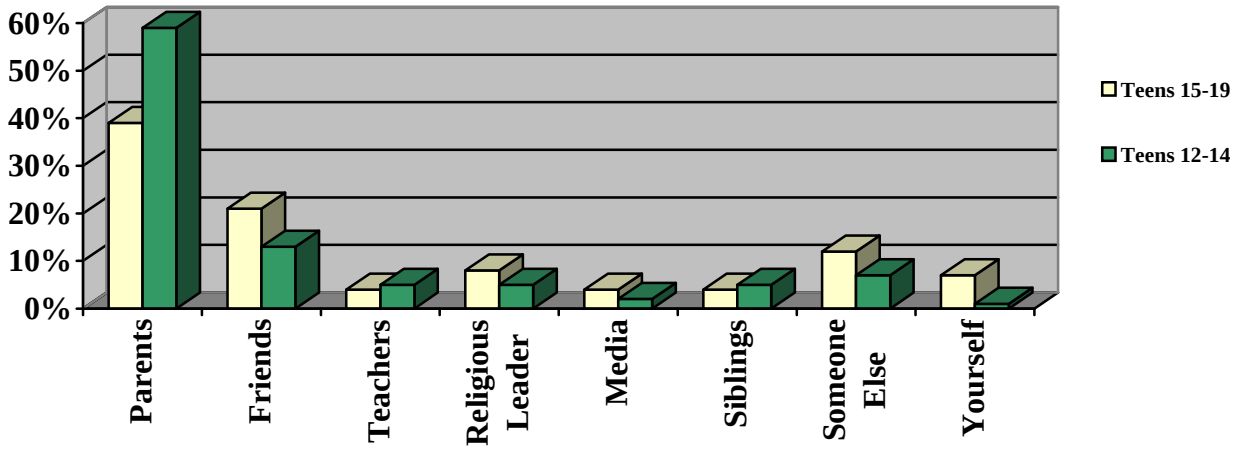
Glacier, Big Horn, Roosevelt, Blaine, Rosebud, Hill, Mineral, Cascade, Lake, and Yellowstone counties have the top ten highest five-year rates (2001-2005) of teen pregnancy in the state.

More than forty years of research has been dedicated to teen pregnancy prevention, with the National Campaign to Prevent Teen and Unwanted Pregnancy emerging as the leader in research in this area. Using risk and protective factors from their recent publication, *Emerging Answers 2007*, this report provides insight into the statewide influencers of teen pregnancy. These factors are broken down into various "domains" including community, family, peer and individual. Two state-sponsored surveys, the Youth Risk Behavior Survey and the Prevention Needs Assessment, use similar domains (with some variation in definition) to poll Montana students on their exposure to certain risk and protective factors for teen pregnancy.

Although each pregnant teen experiences a unique situation, factors such as family disruption, being economically disadvantaged, peers who engage in rebellious and high-risk behavior, using alcohol and/or drugs, and having multiple sex partners may contribute to an increased risk of teen pregnancy. Factors such as high family connectedness, parent-child communication, condom/contraceptive use, and greater connectedness to school are more likely to protect teens from pregnancy.

Families and parents continue to be the most influential people in a teen's life, in large part; parents must initiate conversations with teens on sexuality. Younger teens are more likely than older teens to cite parents as being most influential. Research from the National Campaign to Prevent Teen and Unplanned Pregnancy suggests that teens want their parents to bring up these topics to them; they do not want to be the ones to bring them up to their parents.[5]

Figure 4: Responses to "When it comes to descisions about sex, who is the most influential?" , females and males, by age group



PREGNANT TEENS IN MONTANA

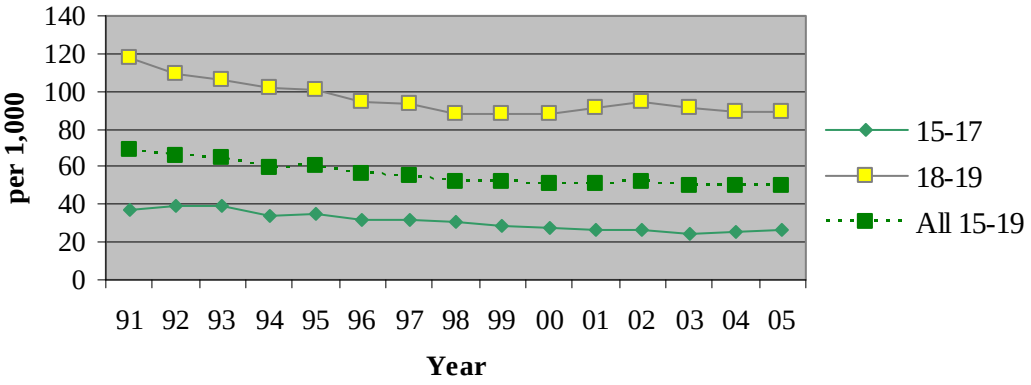
Age. Most pregnant teens in Montana are 18 or 19 years of age. Over the past 15 years, the pregnancy rate for all age categories has declined. However, as Figure 5 shows, the decline in Montana teen pregnancy rates occurred primarily between 1991 and 1999.

Teen pregnancy rates per 1,000, by age group

	15-17	18-19	15-19
MT (2005)	25.9	88.6	49.3
US (2002)*	42.3	125.6	75.4

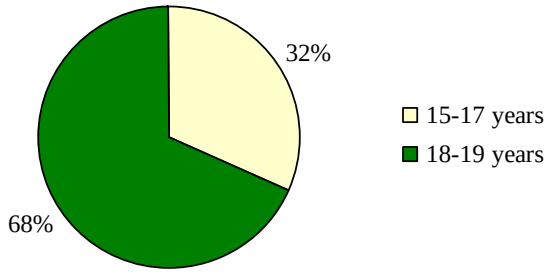
*most recent year for which data is available

Figure 5: Teen pregnancy rates, females ages 15-19, Montana, 1991 - 2005



State and national teen pregnancy statistics are broken into three age categories: 18-19 year olds; 15 -17 year olds; and teens under the age of 15. Teens in each category differ markedly from one another in biological and social maturity, in educational level, and in legal status. **Please Note: because of the low number of pregnancies of teens under the age of 15, the charts and tables focus on teens between 15 and 19 years of age.**

Figure 6: Distribution of teen pregnancy, by age group, Montana, 2001- 2005



PREGNANT TEENS IN MONTANA

Eighteen and nineteen year old teens are still considered adolescents although they may have limited adult rights and responsibilities (i.e., voting). Older pregnant teens in Montana are characterized by the following:[6]

- Education. Slightly more than half of older teens who give birth are high school graduates (52%); another 7% have completed one or more years of college. However, more than one-third (40%) have not completed high school by the time their babies are born.
- Prenatal care. Older teens that carry their pregnancies to term are more likely than younger teens to seek prenatal care within the first trimester (70%) and make nine or more prenatal visits (72.1%).

Fifteen to seventeen year old teens are considered minors in the eyes of the law. They are characterized by the following:[7]

- Education: Most teens in this age group who give birth are still in high school (89%) while 10% are high school graduates.
- Prenatal care. For those young teens whose pregnancies resulted in a live birth, only 62% began prenatal care within the first trimester; 66.5% had 9 or more prenatal visits to a health care professional.

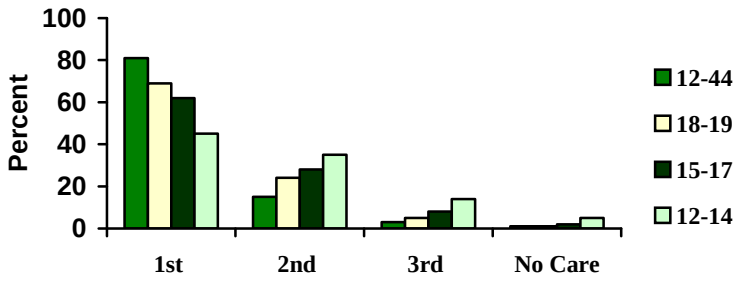
The younger the pregnant teen, the less likely she was to seek prenatal care in the first trimester of pregnancy.

Teens under age 15 are referred to as "very young teens" and are characterized by the following:[8]

- Education. A little over half of very young teens who give birth under age 15 have an eighth grade education (55%) while 21% have completed the 9th grade. One in five (20%) teens younger than 15 have less than an 8th grade education.
- Prenatal care. For those very young teens whose pregnancies resulted in a live birth, less than half (45%) begin prenatal care within the first trimester. Only 3 of 5 (59.4%) make 9 or more prenatal visits.

In 2005, there were 22 pregnancies reported among Montana teens ages 14 years and younger.

Figure 7: Trimester prenatal care began, by age group, Montana, 1991-2005



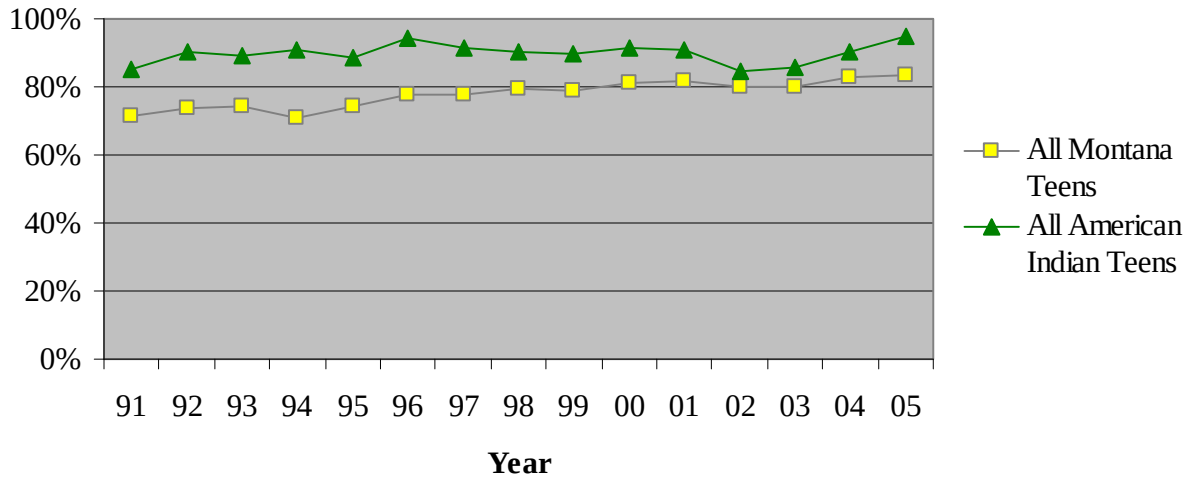
Prior Pregnancies. Approximately one in four pregnant teens (26%) in Montana has had a previous pregnancy.[9] This percentage has decreased slightly since 1991 when 29% of pregnant teens reported being pregnant before.

Older pregnant teens are more likely to have had a previous pregnancy. Of pregnant 18 and 19 year old teens in Montana in 2005, one in three (29%) reported a previous pregnancy. During the same time period, 15% of 15 to 17 year old teens had reported a previous pregnancy.

Marital Status. Since 1991, premarital childbearing has increased not only among teens, but also among women of all ages. Being unmarried and having a baby has a growing level of acceptance in American society.[10] The US Census reports that in the 1930's, 82% of first births occurred to married women compared to 59% of first births in the 1990's.[11]

Among all Montana teens ages 15 to 19, 86% of births were to unmarried females. Patterns of marriage and childbearing among Montana teens differ according to the mother's race. Children born to unmarried mothers represented 82% of all births to White teens in 2005; in 1991they accounted for 68% of births. Among American Indian teens, 95% of children were born to unmarried mothers in 2005; this proportion has increased from 85% in 1991.

Figure 8: Percent of live births to unmarried teens ages 15-19, Montana, 2001-2005



PREGNANT TEENS IN MONTANA

According to the US Census (2003), the median age at first marriage has increased for both men and women, and is now reaching 27 years for men and 25 years for women. In Montana, the median age for first marriage is 24 for women and 26 for men.

The median age for first marriage in Montana tends to be lower than it is nationally.

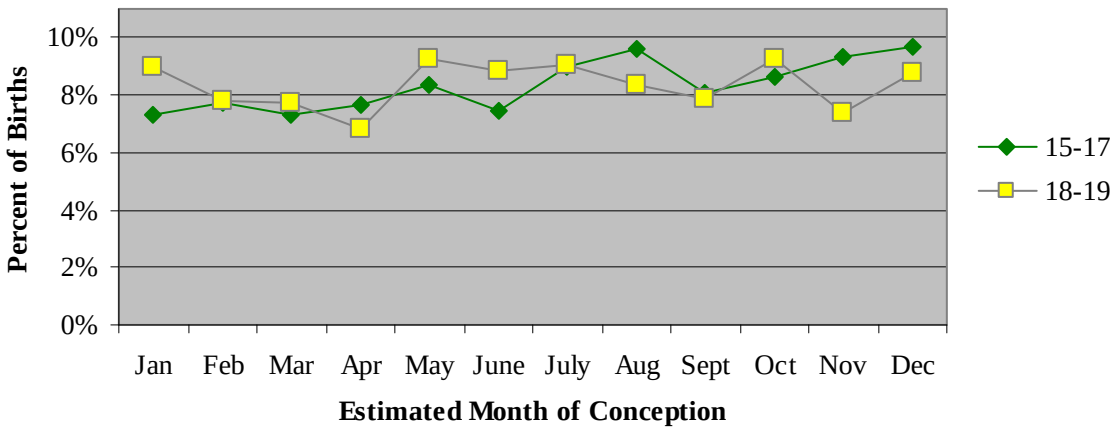
Patterns of Teenage Sexuality. The National Campaign to Prevent Teen Pregnancy analyzed data from the National Longitudinal Survey of Youth 1997 to determine which month teens first have sex. This survey reports on a nationally representative sample of 8,984 teens born between 1980 and 1984. Survey results on when teens first have sex do not indicate a difference between summer months (June-August) and months when school is commonly in session (September-May). Twenty-eight percent of teens surveyed in the 1997 National Longitudinal Study of Health reported first having sex during June – August, in other words, one-third of the sample had sex during one-third of the calendar year.[12]

Birth record data do not indicate a peak in summer conceptions for Montana teens.

Other studies have examined the timing of sexual intercourse and conception to determine if there is a pattern in timing of conception for teens. A study conducted by the University of Texas (2001) found only modest variation by month of conception of live births to teens aged 15 to 19.[13] Contrary to popular belief, there was no summer peak in conception.

Montana birth record data indicate that patterns of conception timing are similar among teens and older women. It is difficult to accurately estimate the date a pregnancy was conceived from birth record data. The date of the last menstrual period is the most common method for estimating the gestational age and approximate date of conception, but this method has some limitations. The date of the menstrual period does not necessarily coincide exactly with the date of conception. Spotting during early pregnancy may be mistaken for menstruation. In addition, women, and particularly teens, may have difficulty remembering the date of their last menstrual period; in 2001-2005, infants born to Montana teens 15-19 years of age were less likely to have gestational age recorded on their birth record than infants born to women 20 years of age and over.

Figure 9: Percent of live births by estimated month of conception, teens and non-teens, Montana residents, 2001-2005



PREGNANT TEENS IN MONTANA

Communication within the family…

"Parents and teenagers have remarkably few conversations about sexual matters, often because both parents and teens feel uncomfortable discussing them together. Few parents are willing or able to participate in special programs, but studies consistently indicate that when they do, their communication with their teens and their own comfort with discussing sexual matters is enhanced. These positive effects seem to dissipate with time and under some conditions, but not all conditions may affect teen sexual behavior."

Emerging Answers, 2007

Pregnancy Outcomes.

The majority of recorded Montana teen pregnancies result in a live birth. Figure 12 shows that about one-quarter of recorded pregnancies result in abortion while the number of fetal deaths is too small to represent. For all age groups of Montana teens, rates for pregnancy, birth and abortion have continued to decline over the past 15 years. Because the rates for teens under 15 years of age are based upon very small numbers, that age category has been excluded.

Figure 10: Teen pregnancy outcomes, Montana teens (15-19), 2001-2005

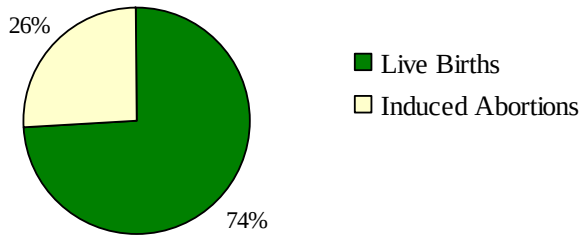
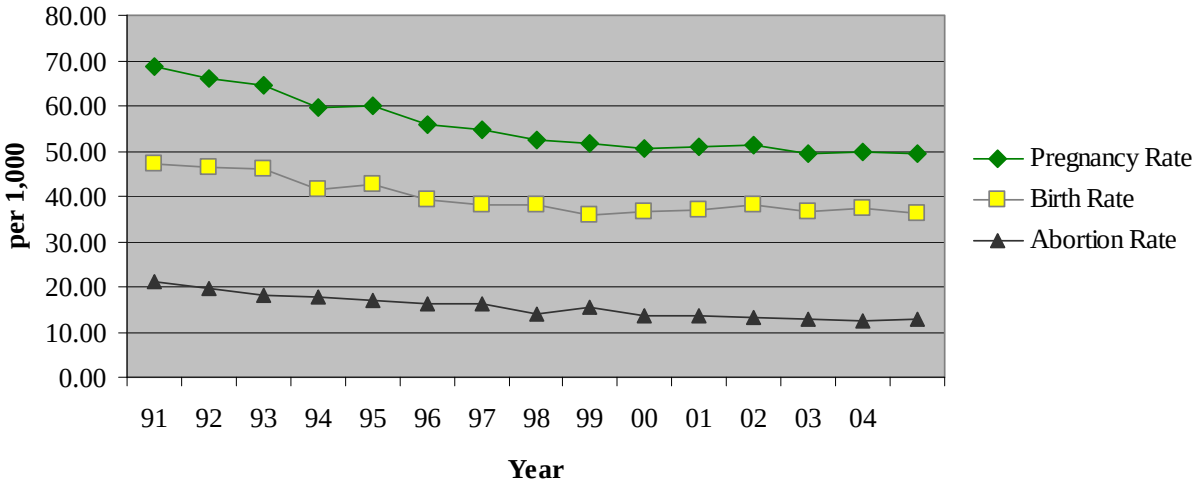


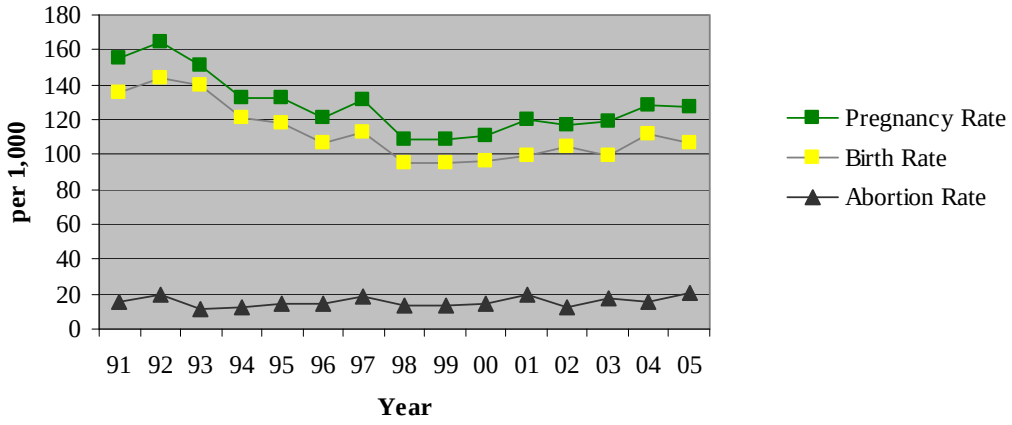
Figure 11: Pregnancy, birth and abortion rates females ages 15-19, Montana 1991-2005



PREGNANT TEENS IN MONTANA

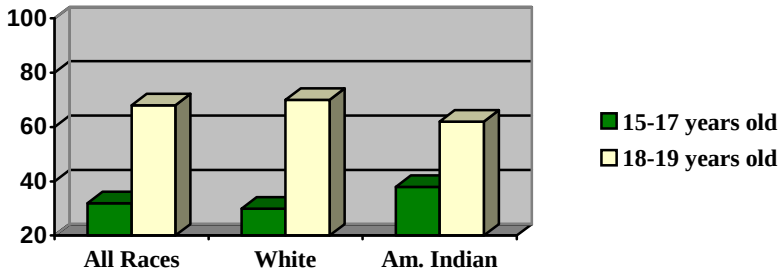
Health Disparities in Teen Pregnancy. Montana residents are not widely diverse. According to US Census estimates for 2006, population distribution by racial groups was as follows: 90.8% White, 6.5% American Indian, 0.7% Asian/Pacific Islander, 0.7% Other, 0.4% Black, and 1.5% two or more races. Persons of Hispanic or Latino origin were estimated to make up just 2.0% of the total population. Since 1980, there has been a slight increase in the proportion of American Indians. According to the 2006 census estimates, the percentage of American Indians has increased to 6.5% from 6.2% in 2000.

Figure 12: Pregnancy, Birth and Abortion Rates, Native American Females ages 15-19, Montana 1991-2005



As Montana's largest minority population, American Indians face many health disparities. Teen pregnancy rates for the Montana American Indian population exceed the state average. In 2005, the teen pregnancy rate for Montana American Indians was 127 per 1,000, compared with 49 per 1,000 for the state as a whole.

Figure 13:Distribution of teen pregnancies, by age group and race, Montana, 2001-2005



In 2005, one in four pregnant teens in Montana was American Indian (25%) and nearly 30% of teen births were to an American Indian mother. The proportion of teen births to American Indian mothers has increased since 2000, when American

PREGNANT TEENS IN MONTANA

Indians represented a little over 23 percent of births to teens in Montana. American Indian teens give birth at younger ages than the general teen population. Over 40% of babies born to a Montana teen in the 15-17 age range are born to an American Indian mother.

In Montana, the American Indian population is younger than the overall population.

Pregnancy and birth rates for American Indian teens ages 15 to 19 in Montana have declined since 1991 (from 154/1000 in 1991 to 127/1000 in 2005). In 2005, the abortion rates are higher than the overall teen abortion rates (21/1000 compared to 13/1000).

FATHERS OF TEEN PREGNANCY

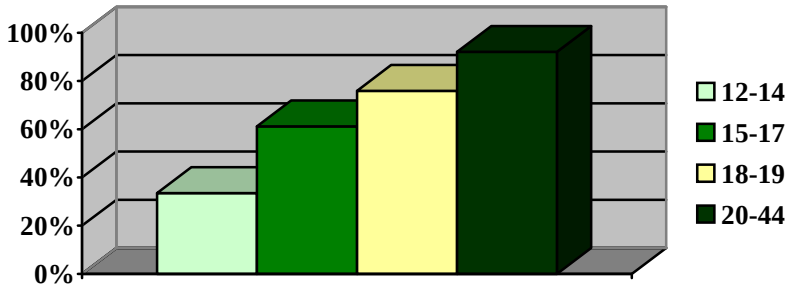
Fathers of teen pregnancy are often overlooked. Most research has been on teen mothers and their children. According to a study published in *Human Reproduction* babies born to teenage fathers are more likely to be born with health problems such as preterm birth, low birth weight, increased risk of adverse pregnancy outcomes and neonatal death than babies born to men over 40.[14] The study chose women 20-29 years old in order to compare just the risks of teen fathers rather than the risks of teen mothers. Pregnancies have significant risks when the mother is a teen, and the risks may be even greater when both parents are teenagers.

1 out of 4 teen mothers report their partner being **at least 4** years older.

Sexual coercion is especially a concern among teens. Most teens do not report information on the fathers, therefore there is limited ability to gather information on the influence of older males on teen mothers. Overall, a quarter of the reported fathers were at least 4 years older than the mother, and the proportion was slightly higher for teen mothers under fifteen (27%).[15] More information needs to be gathered on the fathers of teen pregnancies and especially teen fathers themselves.

Information on fathers is limited because only 71% of teenage mothers include information on the birth records about the father of the baby. Ninety-two percent of mothers age 20-44 reported information on the father. Among teen pregnancies 66% of the fathers are White and 28% American Indian. Only 35% percent of the fathers reported had at least 12 years of education.

Figure 15: Percent of births where information on father reported on birth records, by age group, Montana, 1991-2005



Eighteen to nineteen year old teen mothers are more likely than younger teens to report their partner on the child's birth record (76%) and 35% of fathers ages 18-19 have at least twelve years of education.

Fifteen to seventeen year old teen mothers report their partners' names on the birth record only 61% of the time. Of those reports 28% of the fathers have 10 years of education and 40% are White and 18% are American Indian.

Teen mothers under age fifteen are less likely to name their partners on the birth records (34% reported) than older teens. Due to the lack of reporting, the father's level of education is unknown for 70% of the births. Among the records with paternal information reported, 16% have 10-11 years of education, 11% of reported fathers were White and 17% were American Indian.

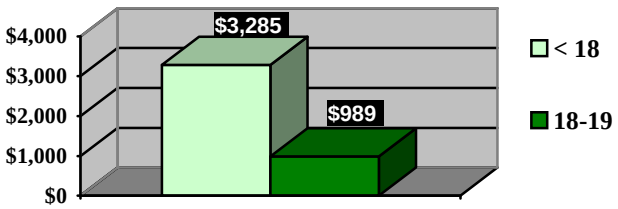
ECONOMIC AND SOCIAL COSTS OF TEEN PREGNANCY

Teen pregnancy and child-bearing have significant economic and social costs. Making further progress in reducing teen pregnancy will both benefit national and state economies as well as improve the educational, health and social prospects for Montanans.

The following is a summary of *By the Numbers*[17], a publication from the National Campaign to Prevent Teen and Unplanned Pregnancy (The National Campaign). The National Campaign states that the teen birth rate in Montana declined 24 percent between 1991 and 2004. This progress saved taxpayers a conservative estimate of $6 million dollars in 2004 alone, including potential lost tax revenue, incarcerations, child welfare programs, and public healthcare programs.

The 18,300 children born to teen parents between 1991 and 2004 cost Montana taxpayers an estimated $300 million. In 2004 alone, the taxpayer burden for teen childbearing in Montana was an estimated $18 million. Of this, 46% were costs to the federal government, while 54% were costs to state and local governments.

Figure 14: Average annual cost of teen birth, by age group, Montana, 2004



The costs to federal, state, and local governments largely represent services that are provided to the children of teen parents. This includes Medicaid, Temporary Assistance for Needy Families (TANF), and incarceration costs. The age of the teen mother at the time of birth substantially affects state costs. The average cost in Montana of a birth to a teen mother 17 years or younger is more than triple the average cost of a birth to an older teen.

Teen mothers are more likely to drop out of school, remain unmarried, and live in poverty. Only 40 percent of young mothers graduate from high school compared to 60 percent of mothers who gave birth at 20 years of age. Young mothers earn $3,350 less per year than mothers who gave birth at 20 years of age. This gap increases to a difference of $11,000 per year by age 30. Lost earnings means lost tax revenue for local, state, and federal governments. In 2004, Montana lost $1 million dollars in potential tax revenue due to lower earning from teen parents.

Children of teenage parents are more likely to be born at low birth weight, grow up poor, live in a single-parent home, experience abuse and neglect, and enter the child welfare system.

Children of teen mothers are **four times** as likely to drop out of school.

Sons of young teen parents are **more than twice** as likely to be incarcerated.

Sons are more likely to be incarcerated. Nearly 14 percent of sons born to mothers 17 and younger will be in prison by their late thirties, compared to 6 percent of sons born to mothers aged 20. Daughters of teenage mothers are three times more likely to be teen mothers themselves than daughters born to women 20 and older (11% compared to 33%). A woman who delays her first pregnancy until she is 20 years or older decreases the chances that her daughter will be a teenage mother by 60%.

RISK AND PROTECTIVE FACTORS

Teens who are at risk for teen pregnancy are also at risk for sexually transmitted infections, dropping out of school, the use of tobacco, alcohol and drugs, engaging in violence and crime, and depression and suicidal thoughts. Risk factors have a cumulative affect on behavior, increasing the likelihood for poor health and social outcomes. Although there are many possible risk and protective factors related to teen pregnancy, it's important to recognize that each pregnant teen's story is unique.

"Parents and other concerned adults cannot control teens' sexual behavior directly, but they can attempt to affect the factors that influence teens' sexual decisions and behavior. Logic and experience suggest that the more people know about those factors and the more effectively people address them, the more success they'll have in reducing sexually risky behavior." ***Emerging Answers, 2007***

Using an ecological prevention model, Dr. Douglas Kirby identified more than 500 risk and protective factors for teen pregnancy that correspond with five domains: Community, Family, Peer Groups, Romantic Partner, and Individual.[18] From this, approximately 70 factors have been the focus of recent research.

Risk Factors (-)	
Community	1. Greater community social disorganization (violence, hunger, substance abuse)
Family	2. Family disruption (divorce, change to single-parent household) 3. Household substance abuse 4. Physical abuse and general maltreatment 5. Mother's early age at first birth
Peer Group	6. Older age of peer group and close friends 7. Peers use of alcohol, drugs and/or involved in deviant behavior 8. Peers have pro-childbearing attitudes or behavior 9. Peers have permissive values about sex 10. Peers are sexually-active
Romantic Partner	11. Romantic partner is older
Individual	12. African-American or Hispanic 13. Behind in school/ Having problems in school 14. Alcohol use 15. Drug use 16. Part of a gang 17. Physical fighting and carrying weapons 18. Other delinquent behavior 19. Work for pay more than 20 hours/week 20. Depression and thoughts of suicide 21. More permissive attitudes towards premarital sex 22. Dating more frequently 23. Going steady, having a close relationship 24. Ever kissed or necked 25. Greater frequency of sex 26. Have a new sexual relationship 27. Greater number of sexual partners 28. Previous pregnancy 29. History of prior sexual coercion or abuse 30. Same-sex attraction or sexual behavior 31. Being married

RISK AND PROTECTIVE FACTORS

Strategies for reducing the impact of risk factors include providing an intervention that reduces the risk, or providing a protective factor. The following protective factors have been proven to decrease the likelihood of a teen becoming pregnant.

Protective Factors (+)	
Community	1. High proportion of foreign-born residents
Family	2. Live with two parents 3. High level of parental education 4. High-quality family interactions, connectedness, satisfaction with relationships 5. Greater parental supervision and monitoring 6. Parental disapproval of premarital or teen sex 7. Parental acceptance and support of contraceptive use for sexually-active teens 8. Greater parent-child communication about sex and condoms or contraception, especially before the teen initiates sex
Peer Group	9. Positive peer norms or support for condom and contraceptive use 10. Peers use condoms
Romantic Partner	11. Partner supports condom and contraceptive use
Individual	12. Greater connectedness to school 13. Higher academic performance 14. High educational aspirations and plans for the future 15. Being involved in the community 16. Have a religious affiliation 17. Involved in sports (girls only) 18. Higher level of cognitive development 19. Greater internal locus of control 20. Taking a virginity pledge 21. Greater perceived male responsibility for pregnancy prevention 22. Stronger beliefs that condoms do not reduce pleasure 23. Greater value of partner appreciation of condom use 24. More positive attitudes towards condoms and other forms of contraception 25. More perceived benefits and/or fewer costs and barriers to using condoms 26. Greater confidence in ability to demand condom use 27. Greater confidence in using condoms and other forms of contraception 28. Greater motivation to use condoms or other forms of contraception 29. Greater intention to use condoms 30. Greater perceived negative consequences of pregnancy 31. Greater motivation to avoid pregnancy and STI 32. Older age at first voluntary sex 33. Discussing sexual risks with partner 34. Discussing pregnancy and STI prevention with partner 35. Previous effective use of condoms or contraception

RISK AND PROTECTIVE FACTORS

Where should our community focus its efforts?

When designing pregnancy prevention programs, it is important to 1) conduct a local needs assessment identifying risk and protective factors of youth in your community, and 2) focus local resources on interventions that will affect the most change. For example, children raised in single parent homes are more likely to become pregnant as teens; however, communities have little influence to change the characteristics of a family unit. However, STI and pregnancy prevention programs provide protection against teen pregnancy, and local school boards and youth-serving community groups can influence the availability of comprehensive sexuality education. The following tables highlight factors that communities have greater feasibility of changing.

Protective Factor (+)	Intervention
1. Greater parent-child communication about sex and condoms or contraception, especially before teen initiates sex	Pregnancy and STI prevention programs that increase parent-child communication including school homework assignments and programs for parents.
2. Positive peer norms or support for condom or contraception use 3. Peer use of condoms	Sex and STI/HIV education and clinical programs that support condom and contraceptive use for sexually active teens presented in small or large group settings.
4. Taking a virginity pledge 5. Greater perceived male responsibility for pregnancy prevention 6. Stronger belief that condoms do not reduce sexual pleasure 7. Greater value of partner appreciation of condom use 8. More positive attitudes towards condoms and other contraception 9. More perceived benefits –or – fewer costs and barriers to using condoms 10. Greater confidence in ability to demand condom use 11. Greater confidence in using condoms and other contraception 12. Greater motivation to use condoms and other forms of contraception 13. Greater intention to use condoms 14. Greater perceived negative consequences of pregnancy 15. Greater motivation to avoid pregnancy and STI	Pregnancy and STI prevention programs can implement strategies that have been demonstrated to delay the initiation of sex, reduce the frequency of sex and the number of partners, and increase condom or contraceptive use.
16. Older age at first voluntary sex	Pregnancy and STI prevention programs can implement strategies that have been demonstrated to delay the initiation of sex.
17. Discussing sexual risks with partner 18. Discussing pregnancy and STI prevention with partner	Pregnancy and STI prevention programs and clinical programs can implement strategies that increase communication about sexual risks and pregnancy and STI prevention within a relationship.
19. Previous effective use of condoms or contraception	Pregnancy and STI prevention programs and clinical programs can implement strategies that increase effective contraceptive use.

RISK AND PROTECTIVE FACTORS

Risk Factors (-)	
1. Peers' alcohol use, drug use, deviant behavior	If friends can be reached, some pregnancy and STI prevention programs with a youth development emphasis may be able to reduce alcohol and drug use and other non-normative behavior.
2. Peers' pro-childbearing attitudes or behaviors	If peers can be reached, sex education programs can reduce pro-childbearing attitudes and behaviors.
3. Peers' permissive values about sex 4. Sexually-active peers	If friends can be reached, agencies can implement effective abstinence or sex and STI/HIV education programs that change permissive values and delay the initiation of sex.
5. Individual's permissive attitudes towards sex 6. Greater frequency of sex 7. Having a new sexual relationship 8. Greater number of sexual partners 9. Previous pregnancy	Pregnancy and STI prevention programs can implement abstinence education, sex, and STI/HIV education, and clinic protocols that target these factors. Such initiatives have been demonstrated to delay the initiation of sex, reduce the frequency of sex and the number of partners, and increase condom or contraceptive use.

Did you know…

No two sexuality education programs are the same. The process for designing curricula, its content, and its delivery vary. In order to describe the different types of sexuality education, six major classifications have emerged:

***Abstinence-only** ***Comprehensive**
***Abstinence-only-until-marriage** ***Abstinence-based**
***Abstinence-centered** ***Abstinence-plus**

The *Montana Partnership for Sex Education* (comprised of healthcare providers and advocacy groups representing women's issues, people with disabilities, social and economic justice, domestic violence prevention, youth development, and HIV prevention) supports comprehensive sexuality education that:

- is age-appropriate and medically accurate;
- does not teach or promote religion. However, this does not preclude discussion of moral, ethical, or religious views related to sex or sexual relationships;
- stresses the benefits of sexual abstinence while addressing the health needs of adolescents who have had or who are engaged in a sexual relationship;
- provides information about the health benefits and side effects of all contraceptives and barrier methods as a means to reduce the risk of contracting sexually transmitted infections, HIV, AIDS and other diseases and preventing unintended pregnancy;
- encourages family communication about sexuality, including how to prevent unwanted verbal, physical, and sexual advances. This includes information about healthy vs. unhealthy relationships, dating violence, sexual harassment, and sexual violence;
- illustrates how alcohol and drugs can affect responsible decision-making;
- helps young people gain knowledge about the physical, biological, and hormonal changes of adolescence and subsequent changes of human maturation;
- assists young people in gaining knowledge and skills about the specific responsibilities of both relationship partners in consensual sexual decision-making;
- develops healthy attitudes concerning growth and development, body image, gender roles, sexual orientation, and other subjects;
- encourages young people to practice healthy life skills including goal setting, decision-making, negotiation, communication, and stress management; and
- promotes self-esteem, healthy behaviors, positive interpersonal skills, and maintenance of personal safety within relationships including platonic, romantic, intimate, and family relationships.

STATEWIDE INDICATORS FOR TEEN PREGNANCY

In addition to this report, two resources are available to Montana communities that report on indicators for teen pregnancy: the Montana Prevention Needs Assessment (PNA), and the Youth Risk Behavior Survey (YRBS). Due to the fact that both surveys poll Montana students, the data presented do not provide information on the protective and risk factors experienced by youth not currently attending school. Being behind or having problems in school is a risk factor for teen pregnancy, substance abuse, depression and anxiety, delinquency, school dropout, and violence; those students without an attachment to school will most likely have higher rates of risk behavior making them more vulnerable to teen pregnancy.

General Information about the Montana 2006 PNA Survey

The State of Montana has been conducting the Prevention Needs Assessment Community Student Survey (PNA) every other year since 1998. Participation by students throughout Montana has increased, with 15,893 students participating in 1998, 18,728 in 2000 and 19,524 in 2002, 22,044 in 2004, and 19,298 in 2006. Because trends over time are very important in prevention planning, the PNA contains the results of the past three surveys. School personnel and individuals charged with planning prevention services will be able to view the trends over time for alcohol, tobacco, and other drug (ATOD) use, antisocial behavior, and levels of risk and protection.

The PNA Survey is conducted by the Montana Department of Public Health and Human Services, Addictive and Mental Disorders Division, Chemical Dependency Bureau. The survey is administered in even-numbered years and is voluntary.

The survey booklets were designed and scanned, the data analyzed, and the various reports produced by Bach Harrison, L.L.C., under contract with the Chemical Dependency Bureau. Questions regarding the survey can be directed to Jackie Jandt, PNA Project Director and Planning and Outcome Officer, Chemical Dependency Bureau, Addictive and Mental Disorders Division, Department of Public Health and Human Services, PO Box 202905, Helena, MT 59620-2905, phone (406) 444-9656, fax (406) 444-9389, or e-mail jjandt@mt.gov. Additional information on risk and protective factors and PNA data can be found at the Montana Prevention Resource Center Website – www.prevention.mt.gov. To find information, data, and reports, go to the Montana Prevention Resource Center Website, select the "Statistics" toolbar, and then select the link for "Montana Prevention Needs Assessment."

General Information about the Montana 2007 YRBS

The Montana Youth Risk Behavior Survey (YRBS) assists educators and health professionals in determining the prevalence of health-risk behaviors as self-reported by Montana youth. In 1988, the Centers for Disease Control and Prevention (CDC) initiated a process to identify the leading causes of mortality, morbidity and social problems among youth - these were identified and categorized into six risk areas: 1) behaviors that result in unintentional and intentional injuries; 2) tobacco use; 3) alcohol and drug abuse; 4) sexual behaviors that result in HIV infection, other sexually transmitted infections, and unintended pregnancies; 5) physical inactivity; and 6) dietary behaviors. The Montana Office of Public Instruction (OPI) has been involved with this survey project since 1991.

STATEWIDE INDICATORS FOR TEEN PREGNANCY

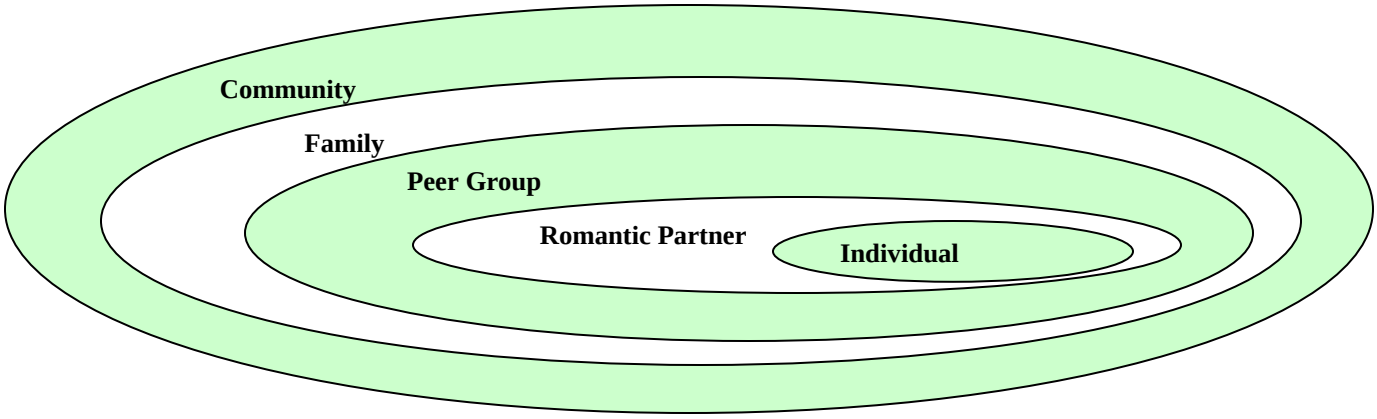
The most recent Montana YRBS was conducted in February 2007. The Montana YRBS results are based on a random sampling completed by 4,030 high school students. The results are representative of all students in grades 9-12 in Montana. The Office of Public Instruction (OPI) acknowledges and appreciates the commitment, cooperation and support of the participating schools and their students.

Go to www.opi.mt.gov/YRBS to access all six Montana YRBS reports, Montana regional data, trend data, Montana versus U.S. data, and school-specific data. Reports are available for high school, grades 7-8, Native American students on reservations, Native American students in urban areas, alternative school students, and students with disabilities.

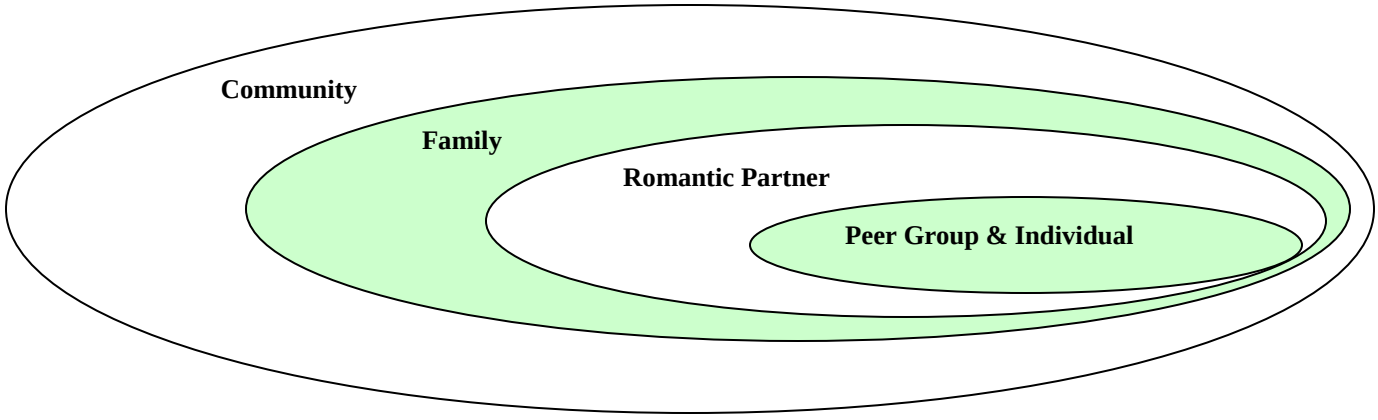
For more information on the Montana YRBS, contact the Office of Public Instruction, P.O. Box 202501, Helena, MT 59620-2501, 1-888-231-9393, Local (406) 444-3095; or Susan Court, 444-3178 or scourt@mt.gov.

Addressing Risk and Protective Factors using an Ecological Model

Emerging Answers identifies five domains for risk and protective factors associated with teen pregnancy: Community, Family, Peer Group, Romantic Partner, and Individual.



For the purposes of presenting risk and protective factors experienced by Montana youth, the Peer Group and Individual domains have been combined. Data collected in the PNA and YRBS is presented as a percent of Montana students, and thus encompasses both an individual student and his/her peers. There is no mechanism in the data collection to specify the risk and protective factors experienced by any individual student.



STATEWIDE INDICATORS FOR TEEN PREGNANCY

Which Risk and Protective Factors Contribute to Teen Pregnancy Statewide?

Community Domain

The Prevention Needs Assessment reports on two indicators related to the community domain: (1) Low neighborhood attachment and (2) community disorganization.

Compared to similar states, Montana students surveyed do not show increased risk associated with the community domain field. This includes questions related to neighborhood attachment, community disorganization, violence, hunger, and substance abuse.

In 2006, 28% of MT eighth, tenth, and twelfth grade students surveyed reported that they would "like to get out of [their] neighborhood." Ten percent of students felt strongly about getting out of their neighborhood. On the contrary, 70% would miss their neighborhood if they had to move.

Figure 15: Percent of students at-risk due to low neighborhood attachment, *MT PNA, 2002-2006*

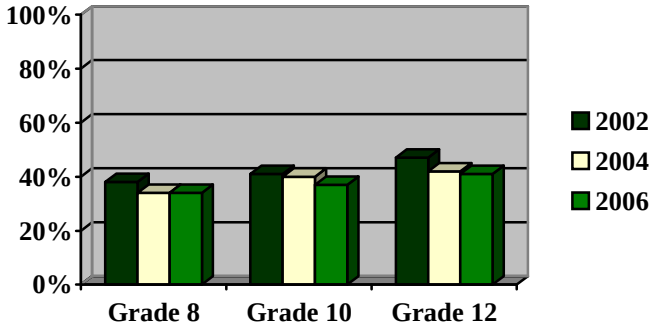
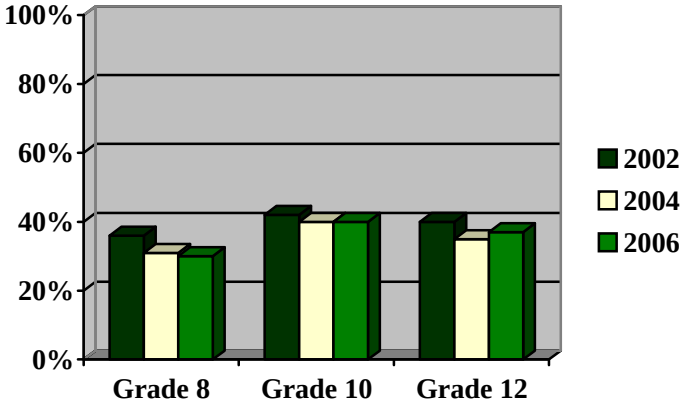


Figure 16: Percent of students at-risk due to community disorganization, *MT PNA, 2002-2006*



When describing their neighborhood, 13% of surveyed MT students report crime and/or drug selling; 15% report fights; 8% report lots of empty buildings; and 12% report feeling unsafe in their neighborhood.[19]

A high percentage of community members experiencing poverty is also an indicator for community disorganization. According to Montana census estimates for 2003-2005, approximately 9% of females aged 12 through 19 lived in households with incomes below 50% of the federal poverty level; 18% lived in households with incomes below 100% of the federal poverty level, and 44% lived in households with incomes below 200% of the federal poverty level.[20]

"Perhaps the most significant issue affecting community attachment is whether residents feel they can make a difference in their own lives. If the key players in the neighborhood, such as merchants, teachers, police, and human service personnel, live outside the neighborhood, residents' sense of commitment will be less. Lower rates of voter participation and parental involvement in schools also indicate lower attachment to the community."
2006 Montana Prevention Needs Assessment

STATEWIDE INDICATORS FOR TEEN PREGNANCY

Family Domain

Many factors within a family contribute to teen pregnancy, including family structure, substance abuse, abuse and maltreatment, high level of parental education, and a parent or sibling experiencing teen pregnancy.[21]

Almost 26% of females ages 12-19 were estimated to live in single parent households in 2003-2005 (21% in female-headed households and 5% in male-headed households).[22]

An estimated 40% of 8th, 10th, and 12th graders are at increased risk for teen pregnancy due to poor family management, monitoring, and supervision. However, this risk decreased between 2002 and 2006. Eighth graders have increased risk associated with family conflict compared to 10th and 12th grade students.

Figure 17: Percent of students at-risk or provided protection due to family factors, MT PNA, 2002-2006

Prevention Needs Assessment: Family Factors									
	Grade 8			Grade 10			Grade 12		
	2002	2004	2006	2002	2004	2006	2002	2004	2006
Percent at Risk									
Poor Family Management, Monitoring	46.1	40.9	39.1	42.9	42.1	37.8	48.6	43.0	41.2
Family Conflict	50.7	50.6	51.2	63.3	38.8	38.5	32.7	33.2	33.8
Percent Protected									
Family attachment	53.5	56.5	54.9	50.0	50.6	49.1	62.3	63.3	62.9

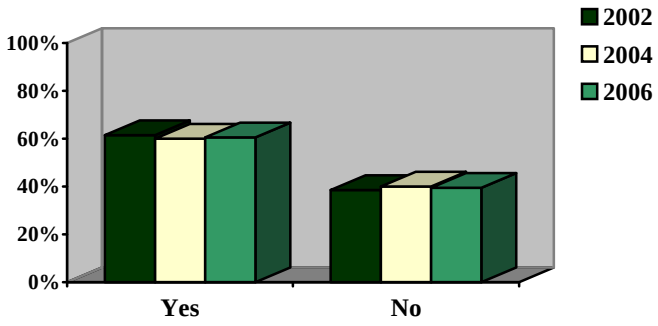
Approximately 80% of surveyed students report satisfaction with their relationships with their parents.

Figure 18: Response to "If I had a personal problem, I could ask my mom or dad for help," by percent, MT PNA, 2006

Response	Grade 8	Grade 10	Grade 12
NO!	8	8	6
No	11	13	11
Yes	34	42	43
YES!	47	38	40

More than half of Montana students report severe alcohol or drug use by a family member.

Figure 19: Response to "Has anyone in your family ever had a severe alcohol or drug problem?"



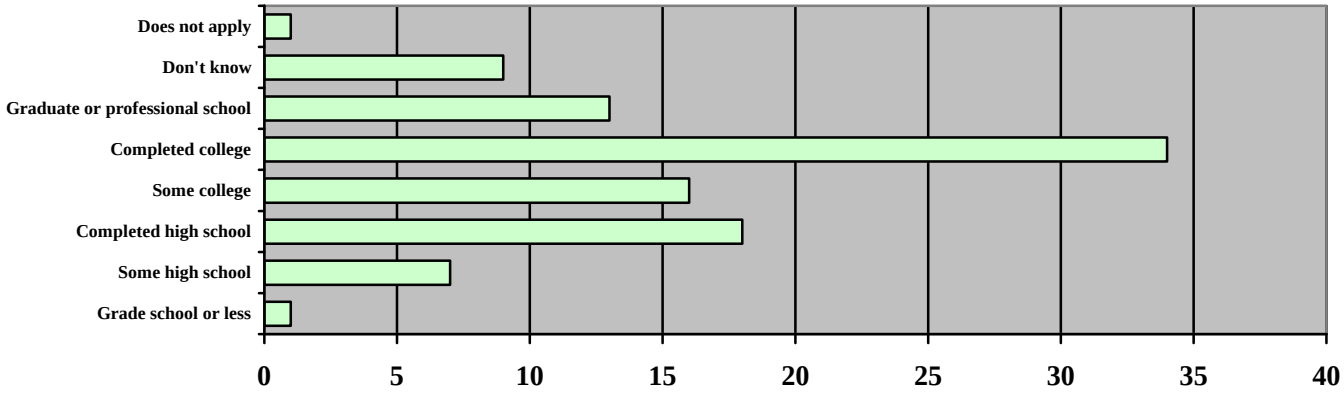
Did you know…

Many adults think that most teens have sex for the first time after school and before their parents arrive home (3 pm- 6 pm). Research from the National Longitudinal Survey of Youth between 1997 and 2000 indicates that only **15%** of first-time sex for teens 16-18 years old occurs during these after school hours. Most first-time sex occurs between **10 pm and 7 am** (42%) and **6 pm-10 pm** (28%). Fifty-six percent of first-time sex occurs in the family home of the teen or their partner. Females are more likely to engage in first-time sex at their partner's home.

STATEWIDE INDICATORS FOR TEEN PREGNANCY

In 2006, nearly seventy percent of surveyed students report that their parents completed at least a high school education. One-third report that their parents completed college.

Figure 20: Education level of parents, reported by Montana students, 2006



Peer and Individual Domains

Several qualities among a teen's peer group many influence their risk of teen pregnancy. These include: having older friends, having friends who use alcohol and/or drugs, having friends who engage in deviant behavior, having friends with permissive values about sex, and having peers who are sexually-active. Three qualities protect against teen pregnancy: 1) peers have positive norms or support condom and contraceptive use, 2) peers use condoms, and 3) attachment to school.[23]

Three indicators from the Prevention Needs Assessment report on alcohol and/or drug use, sensation seeking, and rebelliousness. In all three grades, Montana students are at high risk for sensation seeking. Montana students are at moderate risk for friend's use of drugs and rebelliousness.

Figure 21: Percent of students at-risk or provided protection due to family factors, MT PNA, 2002-2006

Prevention Needs Assessment: Peer/Individual Factors									
	Grade 8			Grade 10			Grade 12		
	2002	2004	2006	2002	2004	2006	2002	2004	2006
Percent at Risk									
Rebelliousness	41.8	43.2	41.0	47.3	48.3	46.5	46.7	44.7	46.1
Sensation Seeking	57.2	66.9	61.6	58.1	65.1	60.9	57.0	63.6	62.7
Friend's use of alcohol/drugs	46.1	41.1	36.7	51.3	44.6	40.4	48.1	40.5	35.8

The following indicators present risk and protective factors for individual teens and their peers. These include sexual behaviors, community involvement, affiliation with a religion, and connectedness to school.

According to the 2007 YRBS, 46% of Montana high school students reportedly have had sexual intercourse, a decrease from 51% in 1993. In 2007, 28% of students in Grade 9 had ever had sex, compared with 59% of students in Grade 12.

STATEWIDE INDICATORS FOR TEEN PREGNANCY

Among sexually active students, 63% used a condom during last sexual intercourse, an increase from 54% in 1995. Montana high school students rank highest in the nation for alcohol or other drug use before sexual intercourse, which may have a significant impact on failure rates. American Indian high school students report higher rates of sexual activity, multiple partners, and alcohol or drug use before intercourse.

Figure 22: Reported sexual risk-taking, high school students, Montana and US, YRBS 2007

2007 YRBS Grades 9-12	All Students		American Indian Students	
Sexual-Related Behaviors	**MT**	**US**	**Res**	**Urban**
Ever had sexual intercourse	46%	47%	67%	57%
Had sexual intercourse with four or more people during their life	14%	14%	26%	22%
Used or whose partner used a condom during last sexual intercourse	68%	63%	73%	61%
Drank alcohol or used drugs before last sexual intercourse	26%	23%	38%	31%

Recent trends show relative stability in sexual debut among high school students, as well as HIV/AIDS education. However, students in Grades 7 and 8 report a decrease in HIV/AIDS education; 84% reported receiving HIV/AIDS education in 1999 to 71% in 2007.

Figure 23: Reported access to HIV/AIDS education in school, MT middle school students, compared to sexual debut, by percent, YRBS, 1991-2007

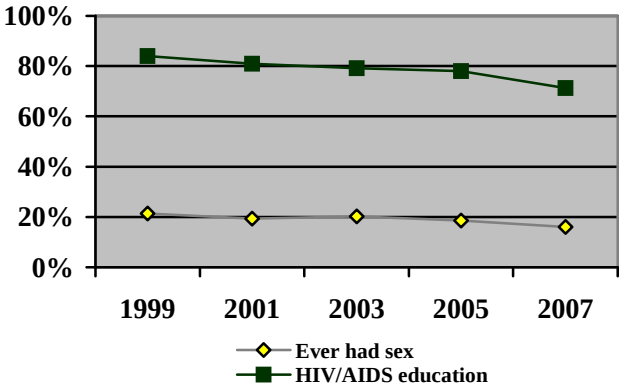


Figure 24: Percent of MT middle school students reporting ever had sex, YRBS 2007

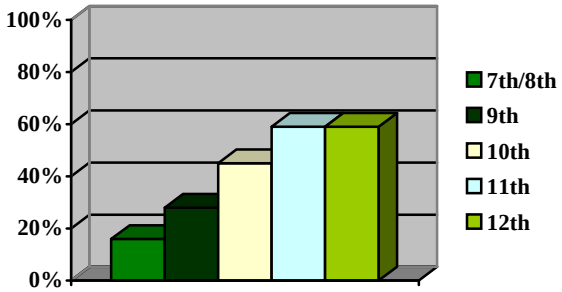
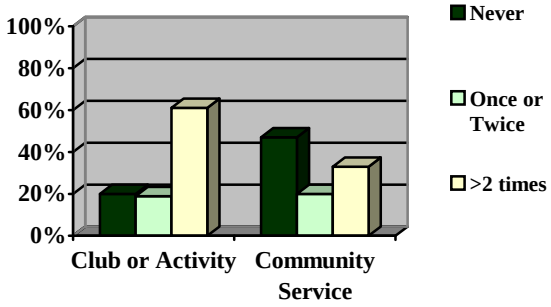


Figure 25: Frequency of Montana high school students reporting community involvement, by percent, PNA 2006

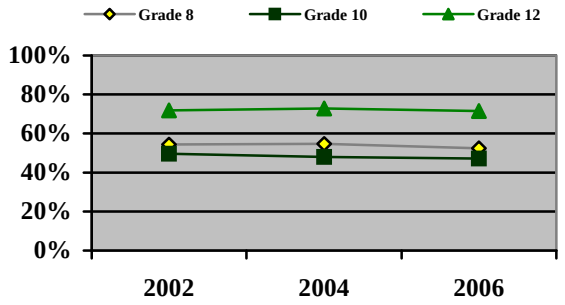


Being involved in the community, such as participating in arts, sports (girls only), service learning, or community programs provides protection against teen pregnancy.[24] According to the 2006 Prevention Needs Assessment, 80% of surveyed students report participating in a club, organization, or activity at their school in the last year. More than half volunteered to do community service. Most who participated in the community did so on multiple occasions.

STATEWIDE INDICATORS FOR TEEN PREGNANCY

Having a religious affiliation provides protection against teen pregnancy. According to the Prevention Needs Assessment, students in Grade 12 are more likely to attend religious services or activities than students in other grades. Students in Grade 10 are least likely to receive protection from a religious affiliation.

Figure 26: Percent of Montana students protected by religiosity, PNA 2006



Student's relationship to their school may also influence their likelihood of experiencing a teen pregnancy.[26] Three statewide indicators are available: academic failure, low commitment to school, and student drop out rates.

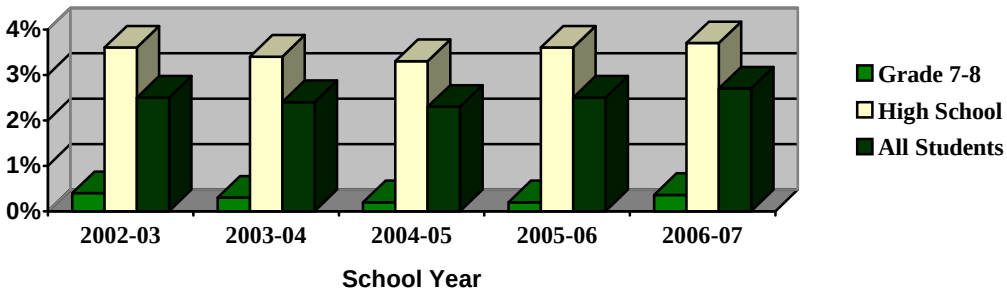
The Prevention Needs Assessment reports that 8th graders experience the greatest risk due to academic failure at 45.9%, with 12th graders experiencing the least at 40.8%. Montana students are at no greater risk compared with similar states.

Figure 27: Percent of students at-risk or provided protection due to school attachment, MT PNA, 2002-2006

Prevention Needs Assessment: School Attachment									
	Grade 8			Grade 10			Grade 12		
	2002	2004	2006	2002	2004	2006	2002	2004	2006
Percent at Risk									
Academic Failure	47.0	46.8	45.9	45.3	46.4	45.8	40.7	39.9	40.8
Low Commitment to School	47.7	45.8	42.7	50.8	49.2	43.5	52.7	49.4	45.5

The Montana Office of Public Instruction reports that the 5-year average drop out rate for high school students was 3.5% in the 2002 and 2006 school years. Drop out rates have remained relatively stable during this period.[27]

Figure 28: Montana Drop Out Rates, by grade, by percent, 2002-2006



BEST PRACTICES

Multiple models are available to implement prevention opportunities that change individual behavior. The *Community Tool Box*, made available by the Montana Prevention Resource Center, provides guidance and tools related to community organizing and prevention, including:

- Assessing community need and resources
- Designing action plans
- Leading a community dialogue on building a healthy community
- Building teams and collaborations
- Evaluating progress

Visit http://ctb.ku.edu to access this tool.

Additional models can be found at the following links:

Building and Sustaining Community Partnerships for Teen Pregnancy Prevention
United States Department of Health and Human Services
http://www.aspe.hhs.gov/hsp/teenp/teenpreg/teenpreg.htm

Get Organized: A Guide to Preventing Teen Pregnancy
United States Department of Health and Human Services and the National Campaign to Prevent Teen Pregnancy
http://www.teenpregnancy.org/resources/research/getorganized/intro.asp

What can *I* do to prevent teen pregnancy?

Teen pregnancy rates in Montana could decrease through individual and community interventions. It is important to recognize that all of us are mechanisms of change, whether you are a parent, an adult, a family member, a teacher, an elected leader, a friend, a schoolmate, or – a teen.

Ultimately, the people in Montana with the most influence to decrease teen pregnancy rates are teens themselves.

Having accurate, research-based information on what works to prevent teen pregnancy is critically important information for communities and practitioners trying to make informed decisions about preventing teen pregnancy. Even so, because teen pregnancy has many causes, and because even effective programs do not eliminate the problem it is unreasonable to expect that any single curriculum or community program to make a serious dent in the problem of teen pregnancy on its own. Making true and lasting progress in preventing teen pregnancy requires a combination of community programs and broader efforts to influence values and popular culture, to engage parents and schools, to change the economic incentives that face teens, and more.

Sarah Brown, CEO
National Campaign to Prevent Teen and Unplanned Pregnancy

BEST PRACTICES

ELECTED LEADERS & POLICY-MAKERS

The National Governors Association (NGA) encourages states to implement a range of strategies for preventing teen pregnancy instead of focusing attention on only one strategy. This range includes:

- Promoting life long responsibility for sexual behavior including abstinence within a context of comprehensive sexuality education.
- Increasing teen access to health services.
- Creating public awareness of teen pregnancy issues, STI awareness and prevention strategies including abstinence.
- Promoting male responsibility for health lifestyles and involvement in deciding reproductive choices, abstinence and parenthood.

Viewing teen pregnancy prevention in the context of a health issue will lead to better health outcomes for teens overall. Teens who are already or who soon plan to be sexually active are at higher risk for pregnancy and sexually transmitted infections. Easy access to reproductive health services contributes to better contraceptive use and lower teenage pregnancy and STI rates, including: knowing where to gain information and services, accessing a provider quickly and easily, receiving confidential and nonjudgmental care, and obtaining services and contraceptive supplies at little or no cost.

This can be accomplished by: 1) maintaining adequate funding for Montana Family Planning Programs to continue providing services to high risk adolescents; and 2) targeting and funding high risk geographic areas within the state for reproductive health services, making sure that such services are evidence-based, and aligned with cultural values and traditions.

Social marketing and public service media campaigns can also bring more awareness to teen pregnancy. Successful campaigns usually follow a three-pronged strategy: changing individual sexual behavior, building positive social and cultural norms for teen behavior, and promoting pregnancy prevention programs and services within the community.

For years, men's role in teen pregnancy has been ignored, focusing attention primarily on the pregnant teen. In recent times, efforts have been made to partner with males to prevent unplanned pregnancies. This includes increased family planning education to men, as well as education on the consequences of unplanned, early fatherhood. Title X family planning clinics provide education, counseling, and clinical services to males.

Share this document with your colleagues and constituents. Make a commitment to teen pregnancy prevention within the state as a way of insuring better educated and more productive adults, healthier children, and a more robust economy.

BEST PRACTICES

HEALTHCARE PROVIDERS

- Explore your comfort and biases surrounding teens and sex.
- Commend teens who seek preventive healthcare for being responsible.
- Transition roles and responsibilities by spending some time alone with your adolescent patients.
- Screen teens for resiliency and social-sexual health issues.
- Encourage teens to discuss their choices with their parents or a trusted adult.
- Listen to teen patients needs. It's hard for adults and teens alike to work up the courage to ask questions.
- Provide contraceptives to those needing them. Make emergency contraception available.
- Services should be confidential and accessible (hours, location).
- Resources:
  http://www.teenpregnancy.org/resources/data/pdf/WhatHelps.pdf
  http://www.ama-assn.org/ama/pub/category/1981.html
  http://www.pediatricsinpractice.org

The American Medical Association (AMA) has developed numerous tools addressing healthcare for adolescents ages 11-21. The AMA states it most accurately in their Guidelines for Adolescent Preventive Services (GAPS) monograph:

> Unintended pregnancy, STIs including HIV, alcohol and drug abuse, and eating disorders are just some of the health problems faced by an increasing number of adolescents from all sectors of society. This health crisis requires a fundamental change in the emphasis of adolescent services – a change whereby a greater number of services are directed at the primary and secondary prevention of the major health threats facing today's youth. School and community organizations have responded to the need for change by increasing health education programming. Primary care physicians and other health providers must respond by making preventive services a greater component of their clinical practice. GAPS can direct providers in how to deliver these services.

Relating to reproductive healthcare, AMA recommends that:

> …all adolescents receive health guidance annually regarding responsible sexual behaviors, including abstinence, latex condoms to prevent STIs, including HIV infection, and appropriate methods of birth control should be made available, as should instructions on how to use them effectively.

All healthcare programs should establish policies around confidentiality and identify how parents should be involved in an adolescent's care.

BEST PRACTICES

EDUCATORS

- Provide medically-accurate comprehensive sexuality education to students, including those in special education tracks.
- Provide training for staff on sexuality education and HIV/AIDS prevention.
- Adopt and enforce school policies on sexual harassment, and drug and alcohol use.
- Provide students with opportunities such as service-learning, which will enable students to connect with their school and community.
- Explore creative ways to educate students on prevention, such as media literacy projects.
- Remember that teens are trying their best to navigate a complicated world. Recognize the majority of teens are making good choices, such as delaying sexual debut, or choosing safer sex options.

The Montana Department of Public Health and Human Services supports comprehensive sexuality education. The Montana Office of Public Instruction recommends a comprehensive sexual health education program that is medically accurate, encourages abstinence, provides information intended to prevent unintended pregnancy and/or STI infection, including HIV, and represents the values of the community as a whole.

Characteristics of Effective Curriculum-based Programs

Process of Developing the Curriculum	The Content of the Curriculum	Implementation of the Curriculum
1. Involved multiple people with expertise in theory, research, and sex and STI/HIV education.	6. Focused on clear health goals- prevention of STI/HIV, pregnancy, or both.	14. Secured at least minimal supports from appropriate authorities (health departments, school district, community organizations).
2. Assessed relevant needs and assets of target group.	7. Focused narrowly on specific types of behavior leading to these goals (abstaining, using condoms/ contraception), gave clear messages, and addressed situations.	15. Selected educators with desired characteristics (whenever possible), trained them, and provided monitoring, supervision, and support.
3. Used a logic model approach that specified health goals.	8. Addressed risk and protective factors – and changed them.	16. If needed, implemented activities to recruit and retain teens and overcome barriers to their involvement (publicity, incentives, consent).
4. Designed activities consistent with community values and available resources.	9. Created a safe social environment for participation.	17. Implemented virtually all activities with reasonable fidelity.
5. Pilot-tested the program	10. Included multiple activities to change targeted risk and protective factors.	
	11. Employed instructionally sound teaching methods (involve participants, personalize information, and change risk and protective factors).	
	12. Employed activities, instructional methods, and behavioral messages appropriate to teen culture, development age, and sexual experience.	
	13. Covered topics in logical sequence	

BEST PRACTICES

PARENTS

- Talk early and often with your children. It's no longer about the one "Big Talk". Be specific.
- Be clear about your values on sex, love, relationships, responsibility, and their goals for the future.
- When the time is right and before child becomes sexually active, discuss sex, condoms and birth control with your son(s) and daughter(s).
- Discourage early dating, especially when the male partner is more than 3 years older that the female.
- Monitor your children. Know where they are, and who they are with.
- Be engaged in your child's education. Value higher education.
- Support comprehensive sexuality education starting in middle school.
- Talk to your healthcare provider about incorporating one-on-one time into your teen's healthcare visits.
- Resources:

  www.thenationalcampaign.org/parents/ten_tips.aspx
  www.familiesaretalking.org
  http://www.noplacelikehome.org

As with all education, sexuality education begins at home. Parental involvement with a teen is the single most important deterrent to early sexual behavior. Parents are the most influential people in a teen's life. This is especially true for younger teens.

Some parents are comfortable discussing sexual values and reproductive health with their children. Others are hesitant due to their upbringing or cultural values. Parents can find tips from the National Campaign to Prevent Teen and Unplanned Pregnancy. Parents can also work together with their physician, a religious leader, school, youth-serving organization, or other trusted individuals to ensure that their children know their family values surrounding sexuality and have the tools to grow into healthy adults.

As parents, it's important not only to start the conversation, but to be approachable and "askable." As events occur in a teen's life, they will need a shoulder to lean on. For resources and tips on becoming an Askable Parent, visit Advocates for Youth at: http://www.advocatesforyouth.org/publications/frtp/askable.htm

BEST PRACTICES

TEENS

- Respect yourself and your health.
- Set a goal for your future and keep your eye on the prize. Consider how an unplanned pregnancy as a teen might affect your future.
- Discuss risks and boundaries related to sexual behavior with your partner early. Your boundaries deserve to be respected.
- Seek advice from your parent(s) or a trusted adult regarding reproductive health.
- Don't use. Never make decisions under the influence of drugs or alcohol.
- If you date, date people who are your own age. Don't date someone more than 3 years older than you.
- Decide when you might want to have sex. This way, you won't be taken by surprise and make a decision under pressure.
- If you chose to be sexually active, be smart. Discuss your plans with your family, your medical provider, and your partner. Protect yourself from unplanned pregnancy and sexually transmitted infections by using condoms and/or birth control.

As a teen, you have a bright future ahead of you! Ask yourself "when is the right time for me to become sexually active?" Make a commitment to yourself. If you have questions about your family's values around sex, ask. Visit www.advocatesforyouth.org for tips on discussing sexual health with your parents.

Be part of the solution. Champion efforts to help teens navigate into adulthood. Join a club, or start a new one. You have good ideas to share.

Change your risk behavior. Smoking, drinking, using drugs, engaging in crime, dropping out of school all increase your risks for teen pregnancy. They will also have an impact on your future.

Identify your interests and skills and use them to make your community a better place. Find ways to volunteer in your community. Ask your school counselor, student council, or visit http://mt.gov/mcsn/services/volunteer.asp for ideas.

Everyone needs help when they are down or confused. Seek help from caring adults (parents, family, clergy, teachers, or counselors) when you are feeling overwhelmed, depressed, unstable, or pressured.

RESOURCES

Advocates for Youth
www.advocatesforyouth.org

Building and Sustaining Community Partnerships for Teen Pregnancy Prevention
http://www.aspe.hhs.gov/hsp/teenp/teenpreg/teenpreg.htm

Child Trends
www.childtrends.org

Emerging Answers 2007, Summary Report
http://www.thenationalcampaign.org/EA2007/default.aspx

Families are Talking, SIECUS
http://www.familiesaretalking.org/

Get Organized: A Guide to Preventing Teen Pregnancy
http://www.teenpregnancy.org/resources/research/getorganized/intro.asp

Guidelines for Adolescent Preventive Services, AMA
http://www.ama-assn.org/ama/pub/category/1981.html

Montana Office of Public Instruction
http://opi.mt.gov/

Montana Office of Vital Statistics, Vital Events data
http://www.dphhs.mt.gov/statisticalinformation/vitalstats/index.shtml

Montana Prevention Needs Assessment
http://www.prevention.mt.gov/pna/2006.asp

Montana Prevention Resource Center
http://prevention.mt.gov/

Montana Youth Risk Behavior Survey
http://www.opi.mt.gov/yrbs/

The Community Tool Box
http://ctb.ku.edu/en/

The National Campaign to Prevent Teen and Unplanned Pregnancy
http://www.teenpregnancy.org/

Women's and Men's Health Section, Montana- DPHHS
http://www.dphhs.mt.gov/PHSD/Women-Health/famplan-index.shtml

Youth Resiliency Screening Tool
http://www.pediatricsinpractice.org

DEFINITION OF TERMS

ABORTION: For the purposes of this report, abortion is defined as induced abortion only and does not include spontaneous abortions (miscarriages).

ABORTION RATE: The number of induced abortions reported to the Montana Department of Public Health and Human Services (DPHHS) compared to the number of live births. In this report, the ration is the number of induced abortions per 1000 live births.

ABSTINENCE: is the practice of voluntarily refraining from some or all aspects of sexual activity.

ADULT: Montana law defines the age of majority as age 18. Individuals age 18-19 are included in the teen rates even though they are legal adults.

AGE-SPECIFIC RATE: The number of occurrences per 1000 individuals in a specific age range (such as females ages 15-19) in a given time period. Most rates in this report are age-specific rates.

BIRTH RATE: The number of live births per 1000 individuals in the population in a given time period. The teen birth rate is the number of live births to females under age 20 per 1000 population of females age 15-19.

COMPREHENSIVE SEX EDUCATION: teaches about abstinence as the best method for avoiding sexually transmitted infections (STIs) and unintended pregnancy, but also teaches about condoms and contraception to reduce the risk of unintended pregnancy and of infection with STIs, including HIV. It also teaches interpersonal and communication skills and helps young people explore their own values, goals, and options.

FERTILITY RATE: The total number of live births as a proportion of the estimated female population at risk, expressed as a number per 1000 women in that population. The population at risk of experiencing birth is all fertile women. The approximation used is all women in the main childbearing ages (15-44 years).

FETAL DEATH: The reported birth of a fetus that shows no evidence of life after complete birth. Montana law requires that fetal death be reported if the fetus weighed 350 grams or more or, if the weight is unknown, if the delivery took place after 20 weeks of gestation.

LIVE BIRTH: The birth of a child who shows evidence of life includes heart action, breathing, and movement of voluntary muscles.

INDUCED ABORTION: A legal medical or surgical procedure that is intended to terminate a pregnancy without live birth.

INFANT DEATH: The death of an individual less than one year old.

DEFINITION OF TERMS

LOW BIRTH WEIGHT: The weight of a live-born infant at 2500 grams (about 5 lbs. 8 oz.) or less.

MORBIDITY: The relative frequency of occurrence of a disease.

MORTALITY: The number of deaths that occur at a specific time, in a specific group, or from a specific cause.

OUT-OF-WEDLOCK BIRTH: A live birth to a female who was not married at any time during the pregnancy.

OUT-OF-WEDLOCK BIRTH RATE: The number of births to unmarried women as compared to the number of all live births, expressed as a number per 1000 live births.

PREGNANCY OUTCOME: The result of a pregnancy including a live birth, an induced abortion, or a fetal death. The number of pregnancies in a given year is the sum of reported live births, induced abortions, and fetal deaths.

PREGNANCY RATE: The number of reported pregnancies per 1000 females ages 15-44 for a given time period. The teen rate is the number of pregnancies to females under 20 years of age per 1000 females ages 15-19.

PROTECTIVE FACTOR: Is an attitude, belief, situation and or action that protects an individual, a group, organization or community from poor health and social outcomes.

RESIDENT/RESIDENCE: For births and fetal deaths, the usual place of residence of the mother. For abortions, the usual place of residence of the patient.

RISK FACTOR: Is an attitude, belief, situation and or action that increase the likelihood for poor health and social outcomes of an individual, a group, organization or community.

SEXUAL COERCION: Is the act of persuading or coercing a minor into engaging in an unwanted sexual activity through physical force, threat of physical force, or emotional manipulation.

SEXUALLY TRANSMITTED INFECTION (STI): Formerly known as venereal disease or sexually transmitted disease (STD), include more than 25 infections passed from one person to another primarily through sexual contact. Gonorrhea, Chlamydia and Syphilis are the only reportable STI's in Montana.

TEEN/TEENAGER: For this report, a teenager is any individual in the age range of 15-19. Specific age groupings are indicated when needed.

VERY YOUNG TEEN: An adolescent under 15 years of age.

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METHODOLOGY

Due to the small numbers of pregnancies in Montana, rates in the following tables and charts are presented for the entire 15-19 year-old age group. It is important to note that presenting rates on this entire age group may obscure some differences in pregnancy rates among younger (15-17 year old) and older (18-19 year old) teens.

Whenever possible in the following charts, county pregnancy rates are presented in single years. For those counties with less than five pregnancies in any of the years (1991-2005), rates are presented in three year aggregates. Rate charts are not shown for counties with less than five pregnancies in each of the three year increments. Small numbers of pregnancies can result in unstable rates, making it difficult to identify trends. The charts are intended to show county-specific trends; charts showing single-year rates should not be compared to charts showing three-year aggregate rates, since the time periods differ.

Tests of statistical significance were conducted to identify statistically significant differences in state and county rates. Five-year aggregate rates (2001-2005) for each county with at least five teen pregnancies during each year were compared to the five-year aggregate state rate for the same time period. A "t" test was used to test for statistical significance using SAS version 9.1: 95 percent confidence intervals were computed and compared to determine whether they overlapped. Overlapping confidence intervals indicates the difference in rates is not significant at the 95 percent level. Confidence intervals that do not overlap indicate a statistically significant difference in rates. This methodology is based on the *Oregon Health Trends Report on Teen Pregnancy (Oregon Teen Pregnancy: County Trends, 1998-2002, an Update*. Oregon Department of Human Services, Center for Health Statistics, Series No. 61, April 2004: accessed at http://www.dhs.state.or.us/dhs/ph/chs/data/newsltr/trends61.pdf) and Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Munson ML. Births: Final data for 2005. National vital statistics reports; vol 56 no 6. Hyattsville, MD: National Center for Health Statistics. 2007: accessed at: http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_06.pdf.

Number of pregnancies among Montana females ages 15-19: 1991-2005																**Total 1991-2005**
County of Residence	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	
Statewide	*1,920*	*1,934*	*1,963*	*1,893*	*1,973*	*1,885*	*1,878*	*1,813*	*1,788*	*1,751*	*1,729*	*1,711*	*1,633*	*1,630*	*1,608*	*27,109*
Beaverhead	15	9	14	17	25	10	18	17	16	17	21	17	13	11	6	226
Big Horn	58	57	53	48	55	70	69	68	50	58	67	58	56	59	55	881
Blaine	17	27	27	29	21	23	26	19	29	24	31	19	20	27	31	370
Broadwater	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	92
Carbon	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	163
Carter	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	12
Cascade	185	213	219	207	214	219	175	207	203	161	193	171	190	162	179	2,898
Chouteau	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	75
Custer	22	27	36	32	32	29	35	28	20	18	15	24	21	15	14	368
Daniels	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	22
Dawson	18	21	18	13	9	9	11	14	10	13	10	12	11	17	11	197
Deer Lodge	33	24	18	23	27	14	29	18	15	17	19	18	9	15	10	289
Fallon	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	52
Fergus	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	205
Flathead	156	150	165	178	175	146	153	143	162	168	155	132	134	147	124	2,288
Gallatin	80	93	95	103	95	100	92	88	91	73	74	91	65	69	87	1,296
Garfield	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	25
Glacier	49	70	71	60	59	55	64	66	60	66	71	74	69	88	76	998
Golden Valley	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	13
Granite	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	47
Hill	57	49	60	48	64	54	55	44	60	40	57	43	37	46	48	762
Jefferson	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	173
Judith Basin	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	18
Lake	67	59	55	50	58	66	62	74	58	69	74	65	85	68	70	980
Lewis & Clark	125	105	103	105	129	135	118	128	99	112	106	103	85	103	97	1,653
Liberty	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	27
Lincoln	53	37	40	40	42	41	46	38	27	43	29	42	33	24	20	555
Madison	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	105
McCone	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	27

Number of pregnancies among Montana females ages 15-19: 1991-2005																Total 1991-2005
County of Residence	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	
Meagher	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	50
Mineral	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	117
Missoula	184	185	190	176	178	170	170	181	188	188	162	181	164	159	162	2,638
Musselshell	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	125
Park	22	24	23	31	21	24	21	24	22	33	21	23	18	11	11	329
Petroleum	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	5
Phillips	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	102
Pondera	8	7	6	10	12	9	13	12	6	11	14	13	14	6	15	156
Powder River	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	30
Powell	12	14	18	15	16	9	14	15	12	14	9	7	8	10	10	183
Prairie	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	15
Ravalli	44	53	51	59	45	40	49	52	56	72	53	50	62	37	56	779
Richland	33	30	17	27	14	14	16	14	15	12	14	10	10	22	10	258
Roosevelt	55	61	62	53	50	41	52	42	47	40	45	57	39	53	56	753
Rosebud	21	42	32	36	38	32	52	24	30	26	27	35	29	38	30	492
Sanders	27	25	13	15	34	21	25	9	26	13	21	21	20	19	11	300
Sheridan	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	55
Silver Bow	96	88	91	77	114	73	73	56	55	47	57	67	48	63	57	1,062
Stillwater	9	15	11	15	9	8	16	8	11	11	17	7	9	6	11	163
Sweet Grass	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	61
Teton	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	83
Toole	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	129
Treasure	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	23
Valley	26	18	19	18	14	23	14	10	14	16	19	9	16	9	7	232
Wheatland	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	49
Wibaux	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	15
Yellowstone	289	268	285	247	261	304	260	280	272	286	251	256	251	236	252	3,998

* Numbers are not reported for counties with less than 5 pregnancies in any of the years.
Pregnancies include live births, fetal deaths (weighing 350g or more or greater than 20 weeks gestation, if the weight is unknown) and induced abortions reported to the Montana Office of Vital Statistics.

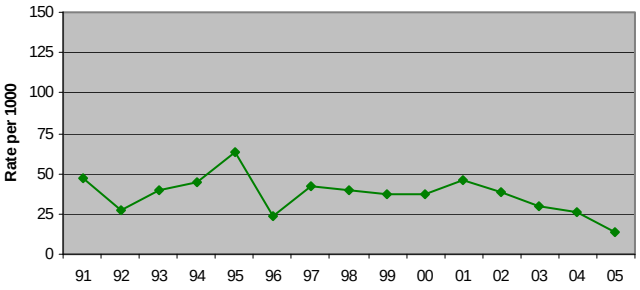
Pregnancy rates among Montana females ages 15-19: 1991-2005																	
County of Residence	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**5-year rate (2001-2005)**	**5-year rate significantly different from state**
Statewide	*68.5*	*66.2*	*64.5*	*59.7*	*60.0*	*55.8*	*54.7*	*52.3*	*51.6*	*50.6*	*50.8*	*51.5*	*49.6*	*50.0*	*49.4*	*50.2*	
Beaverhead	47.3	26.8	39.5	45.2	62.8	23.9	42.6	39.7	36.9	37.6	45.5	38.6	30.2	25.7	14.1	31.1	lower
Big Horn	133.3	126.9	115.5	99.2	108.5	132.1	121.5	117.0	85.5	99.5	118.6	105.1	101.3	107.7	101.9	107.0	higher
Blaine	68.5	105.9	99.6	104.7	72.4	76.4	83.1	59.9	90.6	75.5	104.0	64.4	70.7	93.1	106.2	87.8	higher
Broadwater	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	29.9	
Carbon	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	24.2	
Carter	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	10.7	
Cascade	75.3	82.9	82.2	74.2	75.1	74.9	60.4	70.7	69.3	55.7	71.1	64.9	71.6	61.5	67.2	67.3	higher
Chouteau	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	16.2	
Custer	52.8	62.6	79.8	69.1	67.5	60.9	73.1	58.7	43.0	39.1	34.7	57.7	53.0	39.7	37.9	44.7	not different
Daniels	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	10.8	
Dawson	55.2	63.8	53.6	37.2	24.9	24.1	28.9	37.1	26.8	35.1	27.1	35.7	32.4	52.5	35.6	36.4	lower
Deer Lodge	89.9	65.0	47.2	59.1	69.4	36.1	75.3	46.8	40.8	47.9	57.9	59.8	31.7	51.4	36.0	47.9	not different
Fallon	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	36.0	
Fergus	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	19.9	
Flathead	80.4	72.6	74.9	76.2	70.7	56.8	57.8	53.5	60.1	61.9	57.9	50.3	50.5	54.9	46.1	51.9	not different
Gallatin	34.8	38.6	38.1	39.3	35.8	36.6	33.2	31.0	31.7	25.2	26.2	32.4	23.2	24.1	29.6	27.1	lower
Garfield	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	20.5	
Glacier	108.9	149.9	146.7	117.9	108.3	96.5	107.9	107.5	95.7	103.8	107.9	117.3	106.0	135.6	116.4	116.6	higher
Golden Valley	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	30.8	
Granite	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	28.3	
Hill	91.5	75.4	90.6	72.9	92.5	76.1	75.8	59.6	82.5	55.1	84.1	64.7	55.8	71.1	75.2	70.2	higher
Jefferson	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	23.3	
Judith Basin	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	20.1	
Lake	92.5	78.1	67.7	58.1	63.2	69.1	62.1	72.0	54.8	64.2	65.1	58.9	77.3	61.6	62.5	65.1	higher
Lewis & Clark	71.8	57.5	54.0	53.5	63.1	64.6	56.2	60.4	46.6	52.6	50.1	49.7	41.1	50.8	48.9	48.1	not different
Liberty	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	15.1	
Lincoln	88.9	60.6	61.9	60.0	60.8	58.3	64.8	54.1	38.6	63.0	41.6	61.8	49.6	37.7	31.1	44.6	not different
Madison	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	24.1	
McCone	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	32.2	

Pregnancy rates among Montana females ages 15-19: 1991-2005																	
County of Residence	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**5-year rate (2001-2005)**	**5-year rate significantly different from state**
Meagher	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	51.3	
Mineral	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	68.9	
Missoula	59.2	57.0	55.6	49.9	47.7	44.1	43.3	45.3	46.8	46.8	42.4	47.9	43.8	43.2	44.7	44.4	lower
Musselshell	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	43.4	
Park	56.4	59.3	53.0	68.1	44.6	49.3	42.5	49.8	45.3	68.2	44.2	48.9	39.7	23.9	23.5	36.1	not different
Petroleum	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	0.0	
Phillips	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	24.9	
Pondera	41.9	34.7	28.6	45.2	50.8	35.6	48.3	43.0	21.2	39.0	47.1	46.9	54.7	25.4	64.1	47.7	not different
Powder River	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	17.2	
Powell	72.7	81.4	101.7	82.4	87.0	46.2	70.0	76.9	58.3	71.1	43.9	33.3	39.8	48.5	47.4	42.6	not different
Prairie	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	22.2	
Ravalli	53.9	60.2	54.3	58.3	41.4	35.1	41.5	43.2	46.3	58.6	42.2	39.6	47.5	27.7	41.6	39.6	lower
Richland	87.5	78.1	44.4	69.2	35.4	35.5	40.6	35.7	39.3	32.0	39.2	27.7	28.6	63.2	29.2	37.5	not different
Roosevelt	137.5	151.0	146.6	121.3	109.4	89.3	108.8	87.7	97.7	83.3	88.2	115.9	81.6	113.2	118.4	103.3	higher
Rosebud	48.5	95.2	71.7	78.9	82.6	71.9	119.0	55.4	71.1	62.4	61.6	81.4	67.9	92.0	76.3	75.7	higher
Sanders	90.3	80.9	39.6	43.0	93.2	56.9	67.2	24.5	72.0	35.9	51.5	52.0	51.8	51.5	30.8	47.8	not different
Sheridan	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	23.5	
Silver Bow	84.7	75.8	76.5	63.5	93.7	59.6	59.6	45.6	45.9	40.3	50.6	61.4	44.4	59.4	54.2	53.9	not different
Stillwater	43.7	70.4	48.5	63.0	36.1	30.9	58.8	28.8	38.5	39.1	58.4	25.3	33.7	24.7	43.7	37.6	not different
Sweet Grass	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	30.1	
Teton	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	14.0	
Toole	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	42.6	
Treasure	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	16.7	
Valley	104.8	70.3	71.4	66.2	49.0	79.9	47.1	33.9	49.3	56.3	71.7	37.5	69.9	44.8	37.2	53.4	not different
Wheatland	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	36.3	
Wibaux	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	19.1	
Yellowstone	72.3	64.3	65.9	55.0	56.5	64.5	54.6	58.6	56.9	60.2	54.3	56.8	56.6	53.9	56.8	55.7	higher

* Numbers are not reported for counties with less than 5 pregnancies in any of the years.
Pregnancies include live births, fetal deaths (weighing 350g or more or greater than 20 weeks gestation, if the weight is unknown) and induced abortions reported to the Montana Office of Vital Statistics.

MONTANA COUNTY HEALTH TRENDS

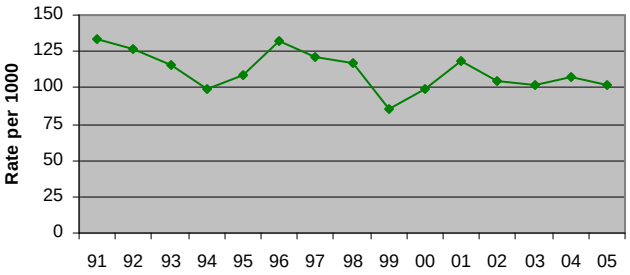
Beaverhead County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



BEAVERHEAD COUNTY

- Five-year average (2001-2005) of 14 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 31.1 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly lower than state rate

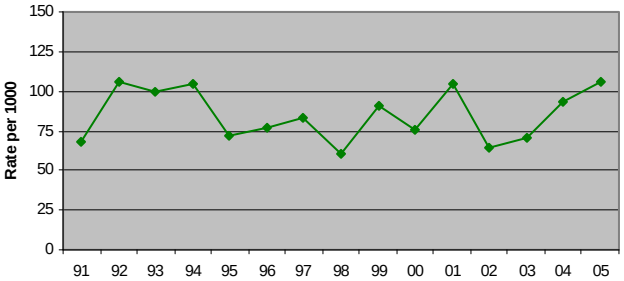
Big Horn County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



BIG HORN COUNTY

- Five-year average (2001-2005) of 59 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 107.0 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly higher than the state rate

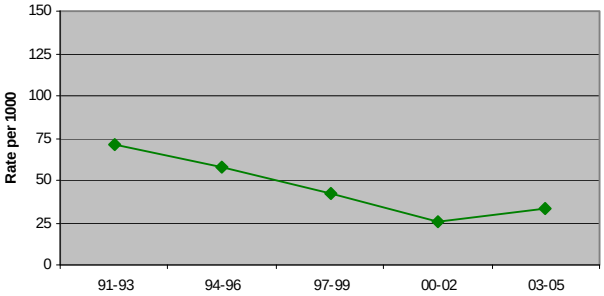
Blaine County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



BLAINE COUNTY

- Five-year average (2001-2005) of 26 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 87.7 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly higher than the state rate

Broadw ater County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

BROADWATER COUNTY

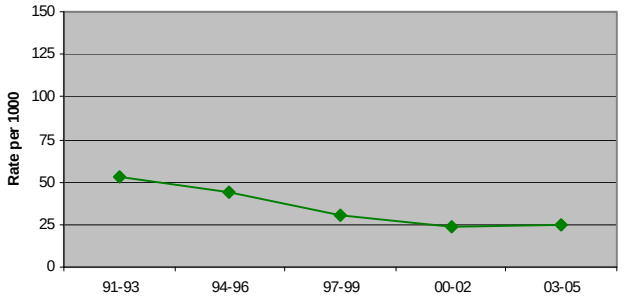
- Five-year average (2001-2005) of 4 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 29.9 pregnancies per 1,000 females ages 15-19

MONTANA COUNTY HEALTH TRENDS

CARBON COUNTY

- Five-year average (2001-2005) of 7 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 24.2 pregnancies per 1,000 females ages 15-19

Carbon County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

CARTER COUNTY

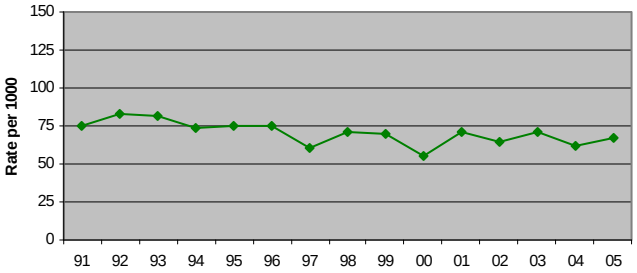
- Five-year average (2001-2005) of 1 teen pregnancy per year
- Five year (2001-2005) pregnancy rate of 10.7 pregnancies per 1,000 females ages 15-19

Trends are not shown due to small number of pregnancies.

CASCADE COUNTY

- Five-year average (2001-2005) of 179 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 67.3 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly higher than the state rate

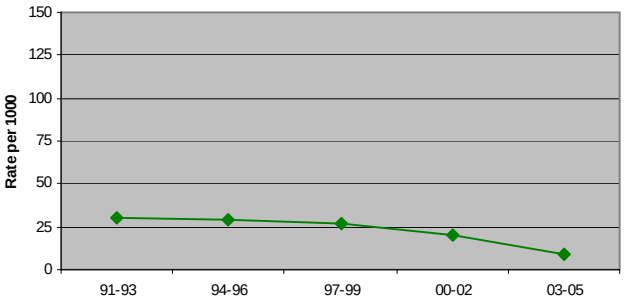
Cascade County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



CHOUTEAU COUNTY

- Five-year average (2001-2005) of 4 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 16.2 pregnancies per 1,000 females ages 15-19

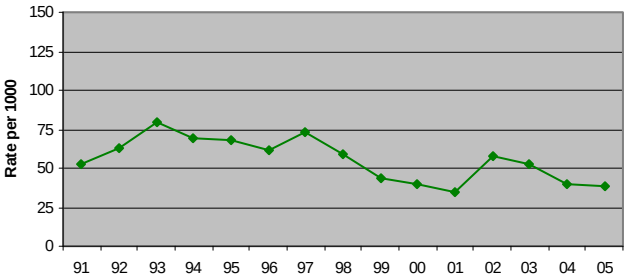
Chouteau County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

MONTANA COUNTY HEALTH TRENDS

Custer County, Teen Pregnancy Rate,
Ages 15-19, 1991-2005



CUSTER COUNTY

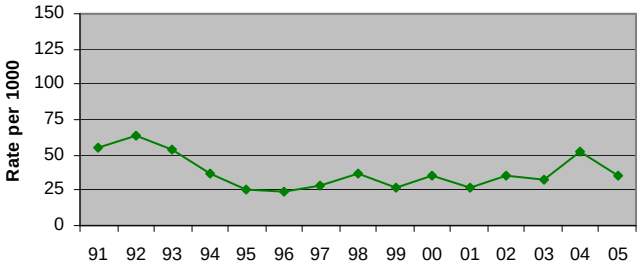
- Five-year average (2001-2005) of 18 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 44.7 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

Trends are not shown due to small number of pregnancies.

DANIELS COUNTY

- Five-year average (2001-2005) of 1 teen pregnancy per year
- Five year (2001-2005) pregnancy rate of 10.8 pregnancies per 1,000 females ages 15-19

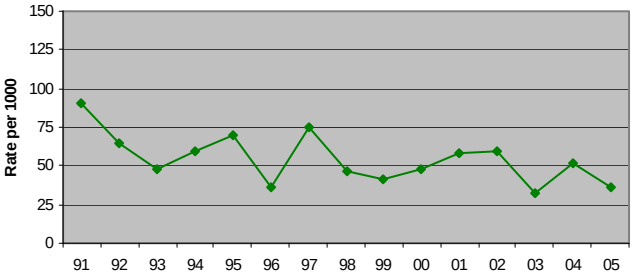
Daw son County, Teen Pregnancy Rate,
Ages 15-19, 1991-2005



DAWSON COUNTY

- Five-year average (2001-2005) of 12 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 36.4 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly lower than the state rate

Deer Lodge County, Teen Pregnancy Rate,
Ages 15-19, 1991-2005



DEER LODGE COUNTY

- Five-year average (2001-2005) of 14 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 47.9 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

MONTANA COUNTY HEALTH TRENDS

FALLON COUNTY

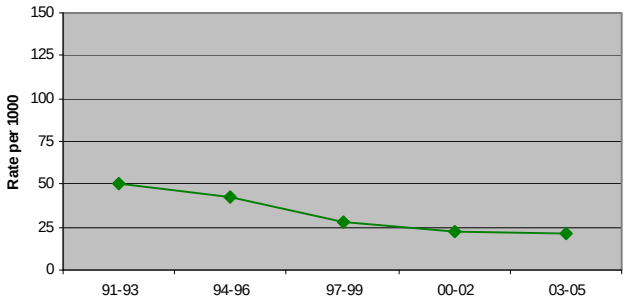
- Five-year average (2001-2005) of 3 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 36.0 pregnancies per 1,000 females ages 15-19

Trends are not shown due to small number of pregnancies.

FERGUS COUNTY

- Five-year average (2001-2005) of 8 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 19.9 pregnancies per 1,000 females ages 15-19

Fergus County, Teen Pregnancy Rate, Ages 15-19, 1991-2005

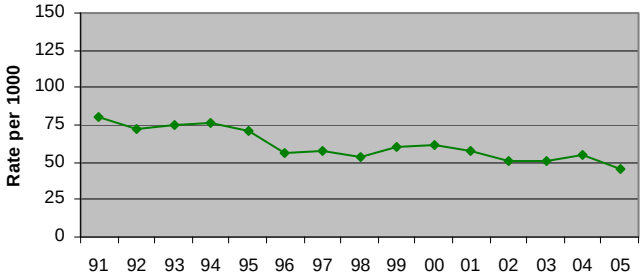


Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

FLATHEAD COUNTY

- Five-year average (2001-2005) of 138 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 51.9 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

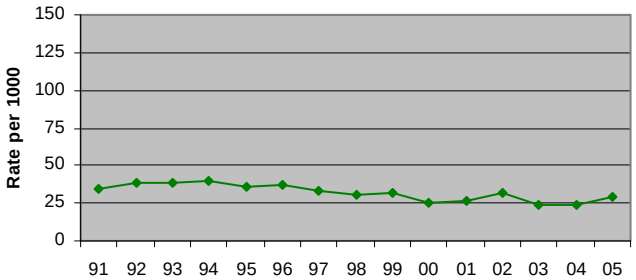
Flathead County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



GALLATIN COUNTY

- Five-year average (2001-2005) of 77 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 27.1 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly lower than the state rate

Gallatin County, Teen Pregnancy Rate, Ages 15-19, 1991-2005

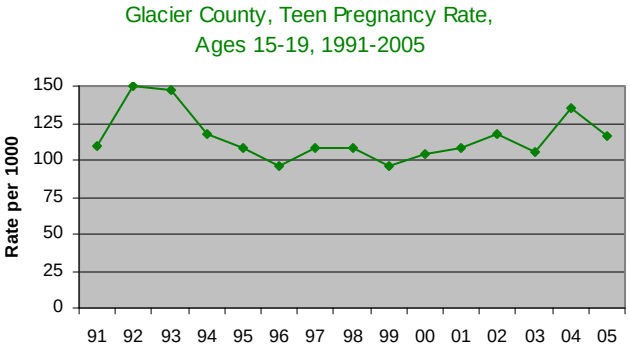


MONTANA COUNTY HEALTH TRENDS

Trends are not shown due to small number of pregnancies.

GARFIELD COUNTY

- Five-year average (2001-2005) of 1 teen pregnancy per year
- Five year (2001-2005) pregnancy rate of 20.5 pregnancies per 1,000 females ages 15-19



GLACIER COUNTY

- Five-year average (2001-2005) of 76 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 116.6 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly higher than the state rate

Trends are not shown due to small number of pregnancies.

GOLDEN VALLEY COUNTY

- Five-year average (2001-2005) of 1 teen pregnancy per year
- Five year (2001-2005) pregnancy rate of 30.8 pregnancies per 1,000 females ages 15-19

Trends are not shown due to small number of pregnancies.

GRANITE COUNTY

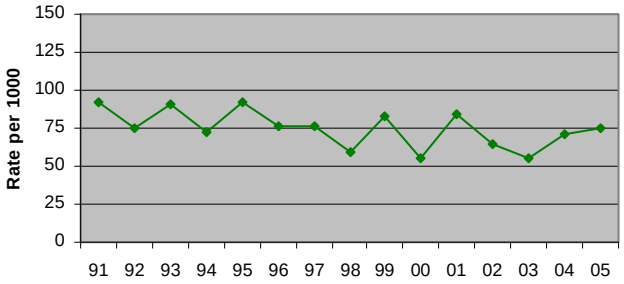
- Five-year average (2001-2005) of 3 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 28.3 pregnancies per 1,000 females ages 15-19

MONTANA COUNTY HEALTH TRENDS

HILL COUNTY

- Five-year average (2001-2005) of 46 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 70.2 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly higher than the state rate

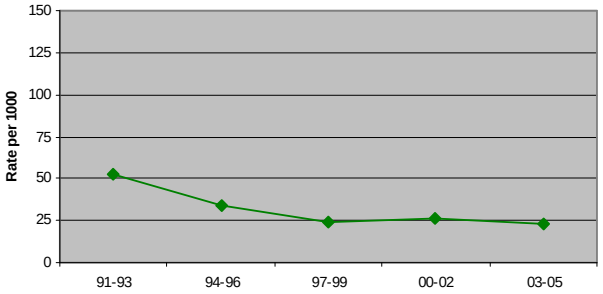
Hill County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



JEFFERSON COUNTY

- Five-year average (2001-2005) of 11 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 23.3 pregnancies per 1,000 females ages 15-19

Jefferson County, Teen Pregnancy Rate, Ages 15-19,1991-2005



Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

JUDITH BASIN COUNTY

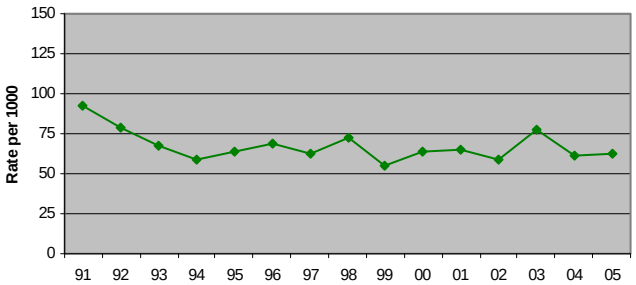
- Five-year average (2001-2005) of 1 teen pregnancy per year
- Five year (2001-2005) pregnancy rate of 20.1 pregnancies per 1,000 females ages 15-19

Trends are not shown due to small number of pregnancies.

LAKE COUNTY

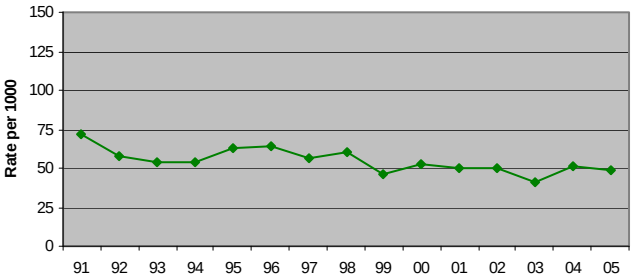
- Five-year average (2001-2005) of 72 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 65.1 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly higher than the state rate

Lake County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



MONTANA COUNTY HEALTH TRENDS

Lewis and Clark County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



LEWIS & CLARK COUNTY

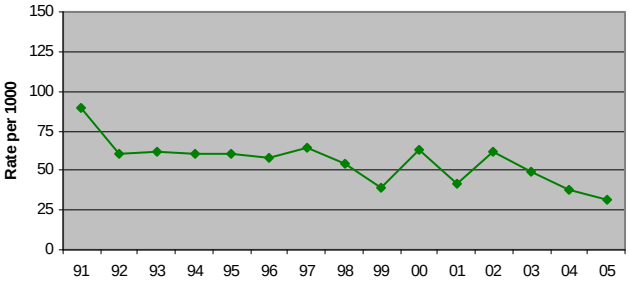
- Five-year average (2001-2005) of 99 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 48.1 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

Trends are not shown due to small number of pregnancies.

LIBERTY COUNTY

- Five-year average (2001-2005) of 1 teen pregnancy per year
- Five year (2001-2005) pregnancy rate of 15.1 pregnancies per 1,000 females ages 15-19

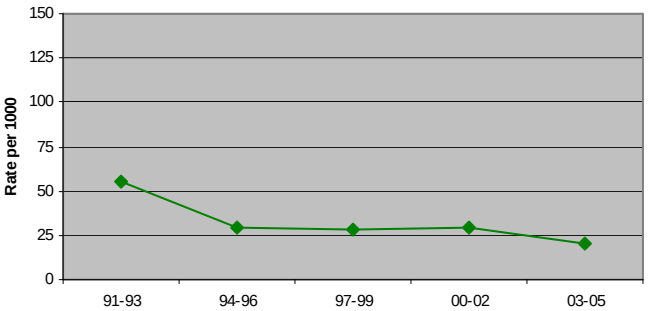
Lincoln County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



LINCOLN COUNTY

- Five-year average (2001-2005) of 30 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 44.6 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

Madison County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

MADISON COUNTY

- Five-year average (2001-2005) of 6 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 24.1 pregnancies per 1,000 females ages 15-19

MONTANA COUNTY HEALTH TRENDS

MCCONE COUNTY

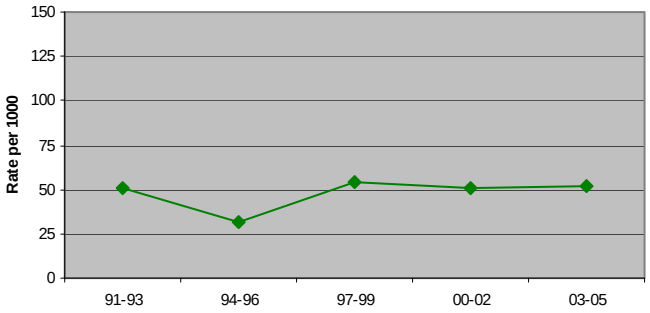
- Five-year average (2001-2005) of 2 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 32.2 pregnancies per 1,000 females ages 15-19

Trends are not shown due to small number of pregnancies.

MEAGHER COUNTY

- Five-year average (2001-2005) of 3 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 51.3 pregnancies per 1,000 females ages 15-19

Meagher County, Teen Pregnancy Rate, Ages 15-19, 1991-2005

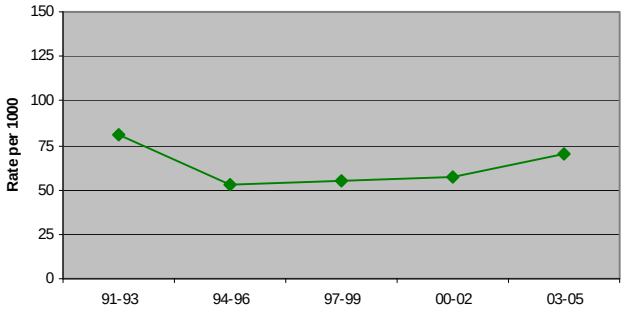


Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

MINERAL COUNTY

- Five-year average (2001-2005) of 8 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 68.9 pregnancies per 1,000 females ages 15-19

Mineral County, Teen Pregnancy Rate, Ages 15-19, 1991-2005

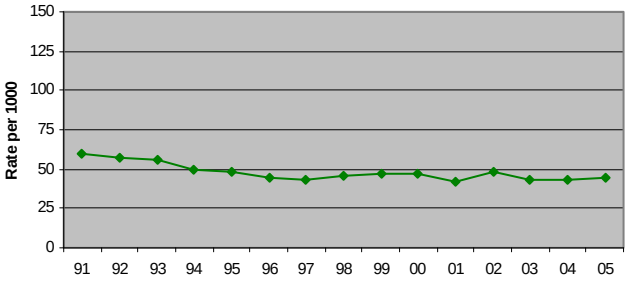


Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

MISSOULA COUNTY

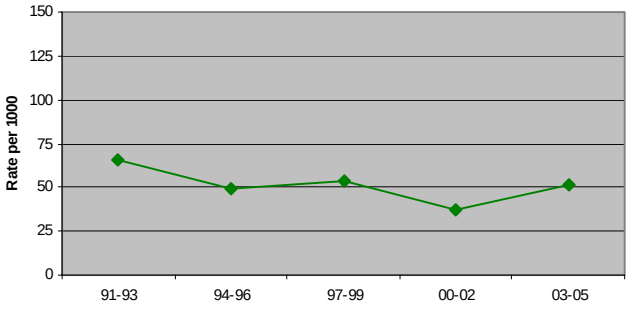
- Five-year average (2001-2005) of 166 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 44.4 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly lower than the state rate

Missoula County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



MONTANA COUNTY HEALTH TRENDS

Musselshell County, Teen Pregnancy Rate, Ages 15-19, 1991-2005

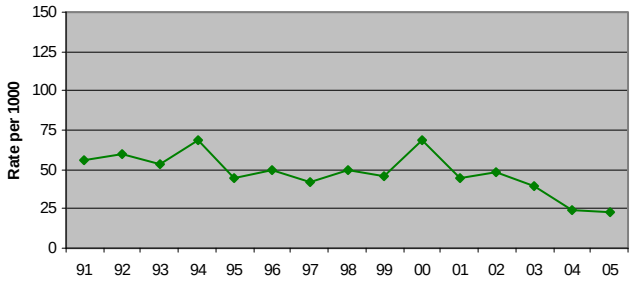


Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

MUSSELSHELL COUNTY

- Five-year average (2001-2005) of 7 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 43.4 pregnancies per 1,000 females ages 15-19

Park County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



PARK COUNTY

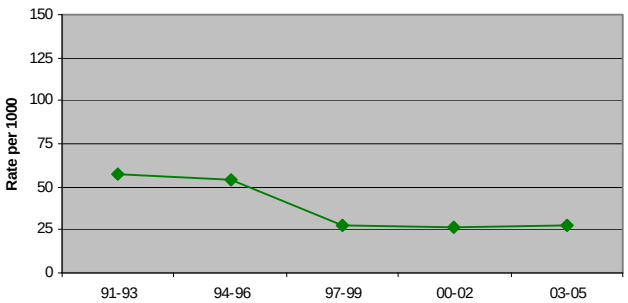
- Five-year average (2001-2005) of 17 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 36.1 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

Trends are not shown due to small number of pregnancies.

PETROLEUM COUNTY

- Five-year average (2001-2005) of 0 teen pregnancies per year

Phillips County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

PHILLIPS COUNTY

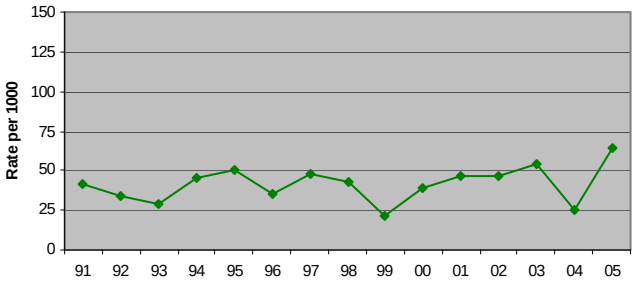
- Five-year average (2001-2005) of 4 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 24.9 pregnancies per 1,000 females ages 15-19

MONTANA COUNTY HEALTH TRENDS

PONDERA COUNTY

- Five-year average (2001-2005) of 12 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 47.7 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

Pondera County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



POWDER RIVER COUNTY

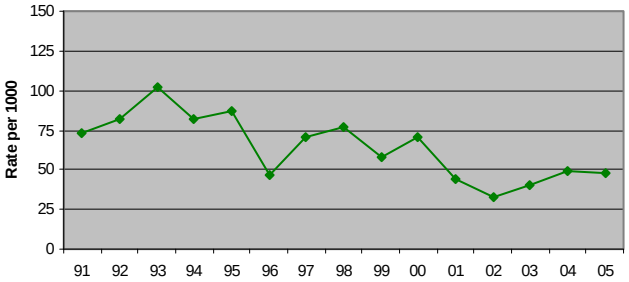
- Five-year average (2001-2005) of 1 teen pregnancy per year
- Five year (2001-2005) pregnancy rate of 17.2 pregnancies per 1,000 females ages 15-19

Trends are not shown due to small number of pregnancies.

POWELL COUNTY

- Five-year average (2001-2005) of 9 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 42.6 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

Pow ell County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



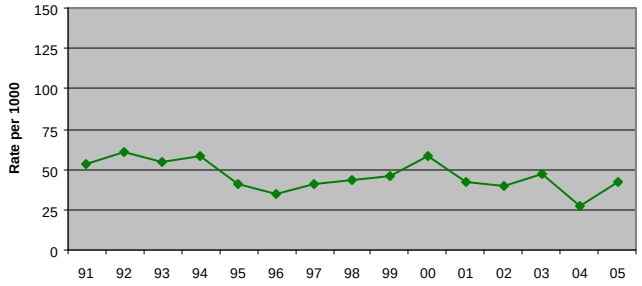
PRAIRIE COUNTY

- Five-year average (2001-2005) of 1 teen pregnancy per year
- Five year (2001-2005) pregnancy rate of 22.2 pregnancies per 1,000 females ages 15-19

Trends are not shown due to small number of pregnancies.

MONTANA COUNTY HEALTH TRENDS

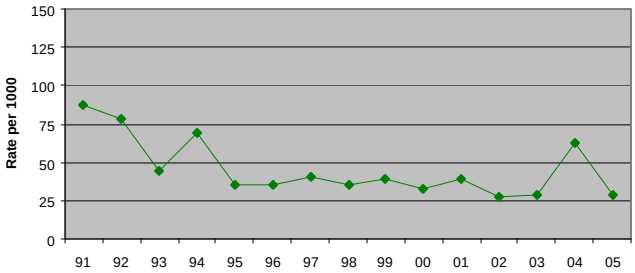
Ravalli County, Teen Pregnancy Rate,
Ages 15-19, 1991-2005



RAVALLI COUNTY

- Five-year average (2001-2005) of 52 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 39.6 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly lower than the state rate

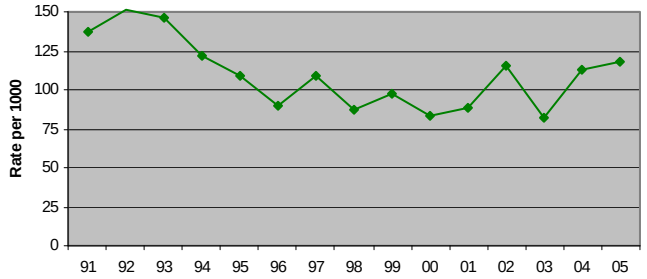
Richland County, Teen Pregnancy Rate,
Ages 15-19, 1991-2005



RICHLAND COUNTY

- Five-year average (2001-2005) of 13 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 37.5 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate.

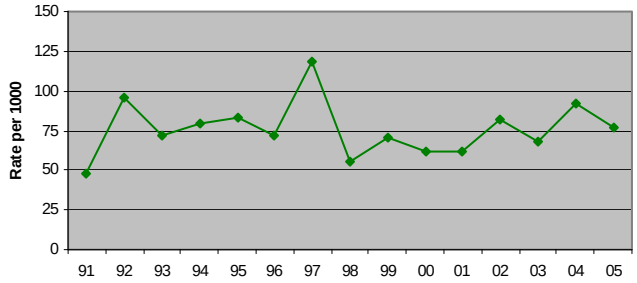
Roosevelt County, Teen Pregnancy Rate,
Ages 15-19, 1991-2005



ROOSEVELT COUNTY

- Five-year average (2001-2005) of 50 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 103.3 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly higher than the state rate

Rosebud County, Teen Pregnancy Rate,
Ages 15-19, 1991-2005



ROSEBUD COUNTY

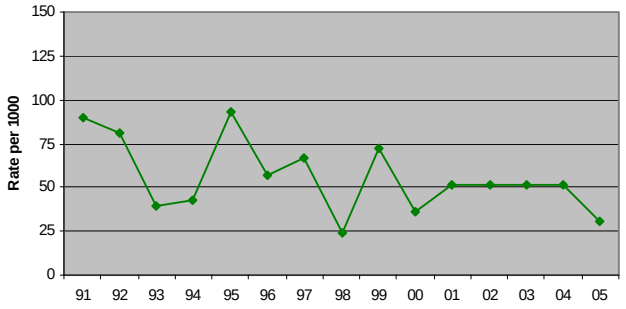
- Five-year average (2001-2005) of 32 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 75.7 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly higher than the state rate

MONTANA COUNTY HEALTH TRENDS

SANDERS COUNTY

- Five-year average (2001-2005) of 18 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 47.8 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

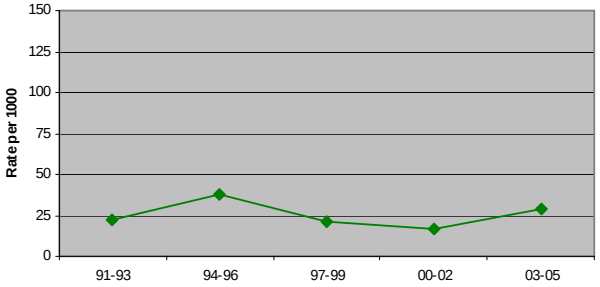
Sanders County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



SHERIDAN COUNTY

- Five-year average (2001-2005) of 3 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 23.5 pregnancies per 1,000 females ages 15-19
- Trend is not statistically significant.

Sheridan County, Teen Pregnancy Rate, Ages 15-19, 1991-2005

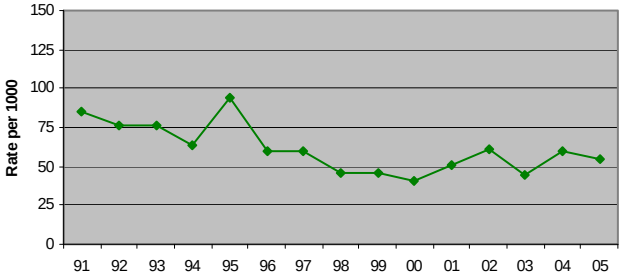


Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

SILVER BOW COUNTY

- Five-year average (2001-2005) of 58 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 53.9 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

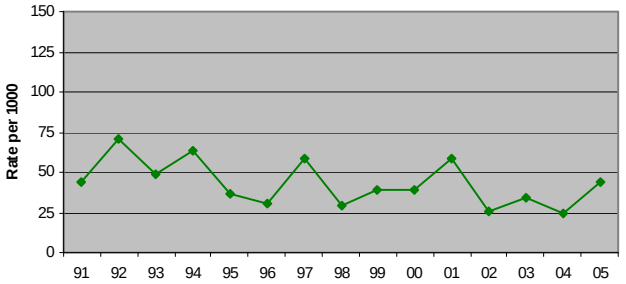
Silver Bow County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



STILLWATER COUNTY

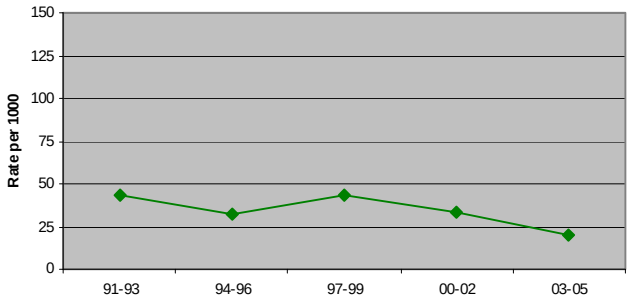
- Five-year average (2001-2005) of 10 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 37.6 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

Stillw ater County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



MONTANA COUNTY HEALTH TRENDS

Sweet Grass County, Teen Pregnancy, Age 15-19, 1991-2005

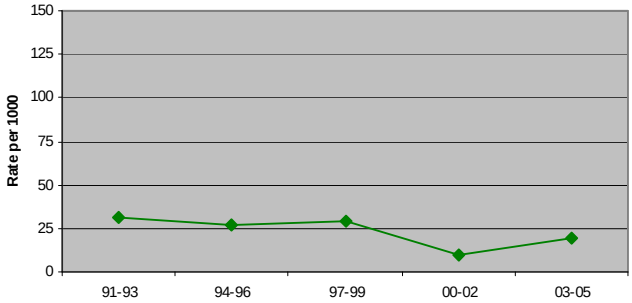


Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

SWEET GRASS COUNTY

- Five-year average (2001-2005) of 4 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 30.1 pregnancies per 1,000 females ages 15-19

Teton County, Teen Pregnancy Rate, Ages 15-19, 1991-2005

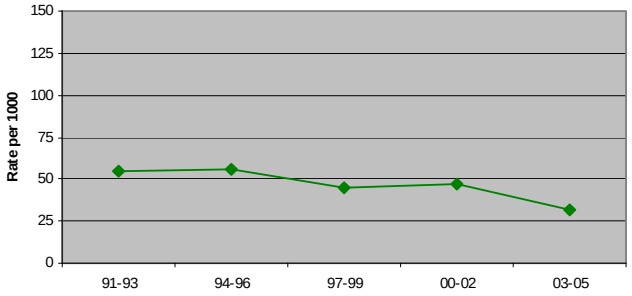


Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

TETON COUNTY

- Five-year average (2001-2005) of 3 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 14.0 pregnancies per 1,000 females ages 15-19

Toole County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

TOOLE COUNTY

- Five-year average (2001-2005) of 8 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 42.6 pregnancies per 1,000 females ages 15-19

Trends are not shown due to small number of pregnancies.

TREASURE COUNTY

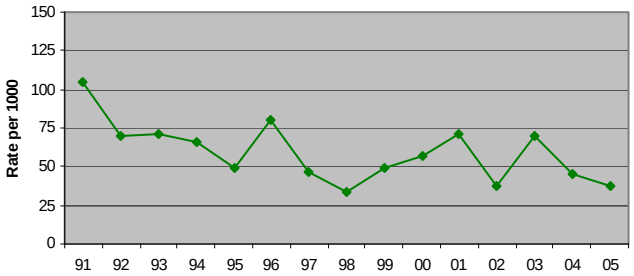
- Five-year average (2001-2005) of 1 teen pregnancy per year
- Five year (2001-2005) pregnancy rate of 16.7 pregnancies per 1,000 females ages 15-19

MONTANA COUNTY HEALTH TRENDS

VALLEY COUNTY

- Five-year average (2001-2005) of 12 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 53.4 pregnancies per 1,000 females ages 15-19
- Five-year rate is not significantly different from the state rate

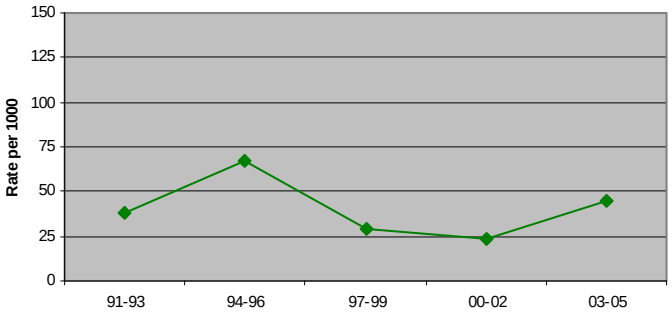
Valley County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



WHEATLAND COUNTY

- Five-year average (2001-2005) of 3 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 36.3 pregnancies per 1,000 females ages 15-19

Wheatland County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



Annual numbers of teen pregnancies are too small to calculate annual rates, so three-year aggregate rates are shown instead.

WIBAUX COUNTY

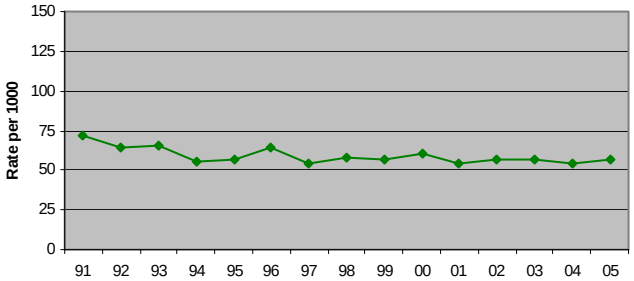
- Five-year average (2001-2005) of 1 teen pregnancy per year
- Five year (2001-2005) pregnancy rate of 19.1 pregnancies per 1,000 females ages 15-19

Trends are not shown due to small number of pregnancies.

YELLOWSTONE COUNTY

- Five-year average (2001-2005) of 249 teen pregnancies per year
- Five year (2001-2005) pregnancy rate of 55.7 pregnancies per 1,000 females ages 15-19
- Five-year rate is significantly higher than the state rate

Yellowstone County, Teen Pregnancy Rate, Ages 15-19, 1991-2005



Big Brother Big Sisters of Montana

Bozeman- Gallatin County, Butte, Billings- Yellowstone County, Flathead County, Great Falls, Helena, Kalispell, Livingston-Park County, Missoula

Cindy Jensen
30 West 6th Avenue
Helena, Montana 59601
Telephone: (406) 442-7479

Risk Factors (-)

1. Family disruption
2. Physical abuse and maltreatment
3. Mother's early age of first sex/ birth
4. Being behind/having problems in school
5. Problem or risk-taking behavior (alcohol use, drug use, violence, delinquency)

Protective Factors (+)

1. Decreased risk-taking (alcohol, substance abuse, skipping school, violence)
2. Increased attachment to community (community participation, improved trusting relationships)
3. Greater connectedness to/ performance in school
4. Improved educational aspirations and plans for the future

Description of Program

For over 100 years, Big Brothers Big Sisters has been the leader in one-to-one youth mentoring with proven success in creating positive friendships that benefit children, volunteers, families, schools, neighborhoods, and the communities nationwide. Big Brothers Big Sisters' best practice prevention methods match professionally screened, caring adults with children from single parent homes that are statistically more likely to engage in risky youth behaviors. Through Community, School, and Business Mentoring programs, these professionally supported relationships are able to build assets in the children served and give volunteers an opportunity to positively impact the life of a child and the community in which they live. The Little Moments that these matches share ultimately make a Big Difference in all of the lives that are touched by the relationship.

Quotes from a Big, and a Little

"During my life I have had to decide which people make a positive or negative influence on me. I make those judgments based off the relationship Bryan and I share… I know that Bryan has made me a more moral and compassionate person than I would have been without him. I also know that being a college bound senior, an honor student, an employee [at the hospital], and a member of the Montana Army National Guard would have been nearly impossible without his guidance, wisdom, and love." Loren, Little Brother

"My first little brother Zac was just 8 when we were matched. Today, he's 30, married with two wonderful daughters, a beautiful home and a good job. He's a great father. He's a productive member of society. And he's a great friend. I did not sit down and `teach' him how to be any of these. But I know – because he has told me – that my influence helped him WANT to be all of these."- John, Big Brother

For more information, visit:

http://www.bbbs.org

Florence Crittenton Home of Montana
Helena, MT

Barbara Burton
Executive Director
901 North Harris Street
Helena, Montana, 59601
(406) 442 6950

Risk Factors (-)

1. Currently pregnant and/or parenting
2. Lack of attachment to family/community
2. Substance abuse
3. Abuse and mistreatment
4. Depression/ Mental health needs
5. Behind/ Problems in school

(This program is comprehensive and works with multiple risk and protective factors. This list is not comprehensive.)

Protective Factors (+)/ Interventions

1. Crisis support and stabilization
2. Chemical Dependency Counseling
3. Interventions to increase satisfaction with relationships (e.g. individual, group, family therapy)
4. Medication management
5. Continuation of Education
6. Life skills (e.g. nutrition, household management, financial literacy, pregnancy & STI prevention education)

Description of Program

Florence Crittenton is a therapeutic program with residential services for pregnant and/or parenting young women who struggle with multiple personal challenges.

We believe the birth of a baby is a unique opportunity for change and growth in the life of a teen mother and her extended family. Through therapy, counseling, education and positive role modeling, we support healthy change in a therapeutic environment where young pregnant and parenting teens can learn new behaviors.

Our relationship based work helps teens who have experienced significant loss, trauma or abuse, address disorganized attachments that might affect their own parenting. Young mothers learn by creating positive, trusting relationships with a caring adult, in order to help them build a strong attachment with their own babies.

Jessica, Age 16

Before arriving at Florence Crittenton I made a lot of really bad choices. I was sixteen, sleeping on the streets, refusing mental health treatment, using drugs, not attending school, and my relationship with my family was a mess. Then I became pregnant.

Florence Crittenton saved my life. I am healthy, clean of drugs, receiving therapy, doing community service, working at a local bakery, learning to be a really good mom and now I want to start studying for a bachelor's degree. I have the most beautiful baby boy you have ever laid eyes on and he is safe and happy.

For more information, visit:
http://www.florencecrittenton.org

Supporting Teen & Other At-risk Parents Program
Bridger Clinic, Inc.
(in coalition with Bridger Alternative School,
The Young Parents Program, Gallatin City/County Health Department, and Thrive)
Bozeman, MT and Belgrade, MT

Cindy Ballew
Health Educator
300 N. Willson, Suite 2001
Bozeman, MT 59715

Risk Factors (-)

1. Currently pregnant or previous teen birth
2. Low attachment to family/community
3. History of substance/ alcohol use
4. Behind/ Problems in school
5. Depression/ Mental health needs

Protective Factors (+)

1. Interventions to increase community attachment
2. Crisis support and stabilization (referrals to support services)
3. Pregnancy & STI prevention education
4. Continuation of education

Description of Program

The 4th Wednesday Lunch and Discussion Group meets at the Bridger Alternative High School and includes pregnant and parenting students and supportive collaborating professionals.

The lunch provides food for students who sometimes do not get enough to eat and support from caring adults. Information is given on contraception, STI prevention, birthing, parenting, housing, job and school related problems, and relationship issues. The discussions are guided by student concerns and interests. Babies are welcome!

Quotes from Participants

"I like to vent and discuss problems. I can do that here" Ciara, age 18

"We get good information every time and usually learn about an event that is coming up that is helpful. Plus there is free pizza!" Joey, age 17

For more information, visit:

http://www.bridgerclinic.gomontana.com/index.html

Missoula Adolescent Pregnancy, Parenting and Prevention Services (MAPPPS)
Missoula, MT
(406) 880-4664
mappps@wordinc.org

Risk Factors (-)

1. Currently pregnant and/or parenting
2. Lack of attachment to family/community
2. Substance abuse
3. Abuse and mistreatment
4. Depression/ Mental health needs
5. Behind/ Problems in school

(This program is comprehensive and works with multiple risk and protective factors. This list is not comprehensive.)

Protective Factors (+)

1. Referral Services
2. Crisis support and stabilization
3. Clinical protocols that delay the initiation of sex, reduce the frequency of sex and numbers of partners, and increase condom and contraceptive use:
   - Individual counseling about the adolescent's own behavior
   - Education on condoms & contraceptives as indicated
   - Education on skills such as partner negotiation and correct condom use
   - Confidentiality
4. Increased access to evidence-based, medically accurate sexuality education

Description of Program

MAPPPS is a coalition of the Missoula Forum for Children and Youth. The Forum is and alliance of prevention coalitions, agencies, and individuals working together to build and maintain a supportive environment for collaborative and proactive work, to help Missoula grow healthy and resilient children and youth. Their mission is to "maintain a community strategy for the prevention of teen pregnancy and to address the needs of pregnant and parenting teens."

Committees within MAPPPS focus on prevention, direct services, and legislative agenda items. Members include: Mountain Home Montana, Futures (WORD), Friends to Youth, Missoula Indian Center, Planned Parenthood of Montana, Early Head Start, Missoula City-County Health Department, YWCA- GUTS!, Meadow Hill Middle School Flagship, Hellgate High School, The University of Montana- Sociology and Sexology Departments.

Quote from MAPPPS Member

"We are a quilting guild of sorts, stitching from all sides of a big blanket, a masterpiece. Our needles are our tireless efforts, the thread our healthy passion, and the patches represent every community member whose life is better because of the MAPPPS coalition."

~Dr. Lindsey Doe, DHS, MAPPPS member

For more information, visit:
http://www.missoulaforum.org/coalitions/mappps

Youth Connections Coalition
Helena, MT

Drenda Carlson, Director
1025 North Rodney
Helena, MT 59601
406-324-1032
dcarlson@helena.k12.mt.us

Risk Factors (-)

1. Family disruption
2. Mother's early age of first sex/ birth
3. Academic failure
4. Lack of commitment to school and community
5. Having friends who engage in problem behavior
6. Favorable attitudes toward problem behavior
7. Early initiation of problem behavior

Protective Factors (+) & Interventions

1. Family and community provide support and clear expectations to youth
2. Increased attachment to community (community participation, improved trusting relationships)
3. Greater connectedness to/ performance in school
4. Improved educational aspirations and plans for the future
5. Serves others in the community

Description of Program

Youth Connections is a community prevention coalition driven to empower youth and promote positive youth development by engaging all sectors of our community to create opportunities for youth to thrive and succeed, and reduce substance abuse and other risky behaviors among youth.

Youth Connections has a six part strategy for affecting underage use of alcohol, tobacco, and other drugs:

- Identify youth with substance use problems and get them the help they need
- Collaborate as a community to prevent underage use
- Provide alcohol free events for youth
- Educate youth on the problem and solutions for youth
- Develop policy to limit underage access to alcohol, tobacco and other drugs
- Share what we know with the whole community

Quote/Anecdotal Story

A Capital High senior who spoke at Youth Connections sponsored Teens & Alcohol: A Town Hall meeting said "the pressure to use alcohol comes from three places: peers, media and low expectations from adults." When adults turn a blind eye or provide a place for teens to drink alcohol, we are sending the message it's ok to engage in risky, unhealthy and illegal behavior. The question we need to ask ourselves, is this the message we should be sending? Teen use of alcohol is a community problem that deserves a community solution.

For more information, visit:

www.youthconnectionscoalition.org

Planned Parenthood of Montana
Clinic Services, Health Education and Outreach
Billings, Great Falls, Kalispell, Helena, Missoula

Jill Baker
Director of Education
211 9th Street South
Great Falls, MT 59405
406-454-3432

Risk Factors (-)

1. Older age of peer group and close friends.
2. Peers' alcohol use, drug use, deviant behavior
3. Sexually active peers
4. Having a romantic partner who is older
5. Going steady, having a close relationship
6. Dating more frequently

(This program is comprehensive and works with multiple risk and protective factors. This list is not exclusive.)

Protective Factors (+)

Pregnancy & STI prevention education:

5. Greater perceived negative consequences of pregnancy
6. Greater motivation to avoid pregnancy and STI
7. Discussing sexual risks with partner
8. Discussing pregnancy and STI prevention with partner
9. More positive attitudes toward condoms and other forms of contraception

Description of Programs

In addition to our confidential medical services for adolescents and adults which include birth control, STI testing, pregnancy testing, pregnancy options education and referrals at each of our clinic sites, Planned Parenthood of Montana offers many educational programs to promote healthy sexuality, postpone sexual activity and delay childbearing until adulthood. Our education programs include parent child workshops addressing the social, emotional, and physical changes during puberty for girls and boys and their adult caregivers; a 6- or 12- part Responsible Choices program that we promote with community organizations including schools, churches and social service agencies; and the Teen Board program, a year-long program in which teens in each of our communities are trained to be peer educators and mentors regarding healthy sexuality.

Quote

"What we learn about and discuss in our peer education group (Teen Board) is so valuable, and we are so fortunate because there are so many people, kids and adults alike, who have never been told about healthy sexuality. Knowledge is so powerful, and it's something that no one can take away from you. The knowledge that I have gained from this experience is something that I wouldn't trade for anything in the world and I'm so grateful that I was able to be part of such an amazing organization."
-Rhiannon S., 2007 Teen Board Scholarship winner and PPMT Board Member

For more information, visit:
www.plannedparenthood.org/montana

Dr. Cathy White, FAAP
Malmstrom Air Force Base,
Great Falls, Montana

Risk Factors (-)

6. Family disruption and mobility (military families move often)
7. Mother's early age of first sex/ birth
8. Behind/having problems in school
9. Problem or risk-taking behavior (alcohol use, drug use, violence, delinquency)

Protective Factors (+) & Interventions

Clinical protocols that delay the initiation of sex, reduce the frequency of sex and numbers of partners, and increase condom and contraceptive use:[25]

1. Individual counseling about the adolescent's own behavior
2. Education on condoms & contraceptives as indicated
3. Education on skills such as partner negotiation and correct condom use
4. Confidentiality

Description of Program

Dr. Cathy White contracts with Malmstrom Air Force Base to provide medical services to dependants of active-duty employees. Though her adolescent patients have similar risk and protective factors to other Montana youth, due to the mobile nature of the military, they experience higher rates of family disruption and less attachment to local communities.

She has adopted the American Medical Association's (AMA) Guidelines for Adolescent Preventive Services (GAPS), including a screening questionnaire, as well as clinical protocols. Key to these recommendations is that at least some time spent with her adolescent patients is alone, without their parents. This teaches them to advocate for their own healthcare and establish an individual relationship with their physician.

For younger adolescent patients aged 9-13, using a tool created by Bright Futures, Dr. White assesses their resiliency in four areas: Belonging, Mastery, Independence, Generosity.

In Dr. White's Words

"Encouraging communication between adolescents and their parents is an important part of pregnancy prevention."

"Many adolescents have things on their minds that they don't want to bring up with their parents present. You'd be surprised how many things aren't medically-related that they ask about; they are just looking for advice from someone they see as an authority. Talk to your provider about allowing some time for your child to meet one-on-one."

"Adolescents who plan ahead and have discussed when they might have sex are less likely to have casual sex and end up with an STI or pregnancy by accident."

For more information, visit:

http://www.ama-assn.org/ama/pub/category/1981.html
http://www.pediatricsinpractice.org/

***Our Whole Lives*- Comprehensive Sexuality Education Program**

Unitarian Universalist Fellowship of Bozeman &
Pilgrim Congregational United Church of Christ

Laura Mentch, Our Whole Lives Facilitator
Unitarian Universalist Fellowship of Bozeman
313 W Mendenhall St
Bozeman, MT 59715
Telephone: (406) 586-1368

Protective Factors (+) & Interventions

1. Congregational support for developing healthy sexual relationships and prevention of unplanned pregnancy and sexually transmitted infections.
   - Identifying characteristics of healthy relationships.
   - Discussing pregnancy and STD prevention with partner
   - Greater confidence in using condoms or other contraception
   - Enhanced communication and negotiation skills
2. Having a religious affiliation
3. Enhanced parental involvement in sexuality education

Description

Our Whole Lives is a comprehensive sexuality education program at work in two religious congregations in Bozeman. The Unitarian Universalist Fellowship of Bozeman and Pilgrim Congregational Church are jointly offering *Our Whole Lives* programs to children, adolescents and adults in their congregations. Each level of the program involves many sessions and participants are encouraged to integrate information about sexuality into many aspects of their life. Parents are actively involved in *Our Whole Lives* programs.

Our Whole Lives is a series of sexuality education curricula for six age groups: grades K-1, grades 4-6, grades 7-9, grades 10-12, young adults (ages 18-35), and adults. An additional curriculum resource, Sexuality and Our Faith, supplements *Our Whole Lives* programs conducted through religious congregations.

Our Whole Lives helps participants make informed and responsible decisions about their sexual health and behavior. It equips participants with accurate, age-appropriate information in six subject areas: human development, relationships, personal skills, sexual behavior, sexual health, and society and culture. Grounded in a holistic view of sexuality, *Our Whole Lives* provides not only facts about anatomy and human development, but helps participants to clarify their values, build interpersonal skills, and understand the spiritual, emotional, and social aspects of sexuality.

The *Our Whole Lives* Values are

1) self worth, 2) sexual health, 3) responsibility, 4) justice and inclusivity.

Quote from a Participant's Parent

"We are very grateful for your efforts to provide these kids with some really important stuff! Never in my wildest dreams had I anticipated such a great opportunity as a parent. Thank you!"

For more information, visit:

http://www.uua.org/religiouseducation/curricula/ourwhole/
http://www.uccbozeman.org/
http://uu.gomontana.com/

Ten Tips for Parents

1. Be clear about your own sexual **values and attitudes**.
2. Talk with your children (boys and girls) **early and often** about sex, and be specific.
3. Supervise and **monitor your children** and teens.
4. **Know your children's friends and their families**.
5. Discourage early, frequent, and steady dating, **especially before age 16.**
6. Take a stand against your daughter **dating an older boy** (4 years), and your son dating a **younger girl**.
7. Help your children develop **goals for their futures**.
8. Let your children know you **value higher education**.
9. Know what your **kids are watching, reading, and listening to**.
10. Build a **strong relationship** from an early age:

    - Express love and affection clearly and often. Hug your children, and tell them how much they mean to you. Praise specific accomplishments, but remember that expressions of affection should be offered freely, not just for a particular achievement.
    - Listen carefully to what your children say and pay thoughtful attention to what they do.
    - Spend time with your children engaged in activities that suit their ages and interests, not just yours. Shared experiences build a "bank account" of affection and trust that forms the basis for future communication with them about specific topics, including sexual behavior.
    - Be supportive and be interested in what interests them. Attend their sports events; learn about their hobbies; be enthusiastic about their achievements, even the little ones; ask them questions that show you care and want to know what is going on in their lives.
    - Be courteous and respectful to your children and avoid hurtful teasing or ridicule. Don't compare your teenager with other family members (i.e., why can't you be like your older sister?).
    - Show that you expect courtesy and respect from them in return.
    - Help them to build self-esteem by mastering skills; remember, self-esteem is earned, not given, and one of the best ways to earn it is by doing something well.
    - Try to have meals together as a family as often as possible, and use the time for conversation, not confrontation.

A final note: **it's never too late** to improve a relationship with a child or teenager. Don't underestimate the great need that children feel--at all ages--for a close relationship with their parents and for their parents' guidance, approval, and support.

Adaptation of *Ten Tips for Parents* from the National Campaign to Prevent Teen and Unplanned Pregnancy

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